South London and Maudsley NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Is this organisation well-led?

Leadership

The trust had a high calibre board in place. The trust board consisted of an interim chair, chief executive, six non-executive directors and five executive directors. The trust appointed an HR director in November 2018, shared across two trusts in the South London Partnership.

The previous chair had been in post for over four years and stepped down in April. The deputy chair became interim chair while the trust recruited a permanent chair. There was a good balance between new and longer established members of the board and this helped to promote stability whilst at the same time encouraging innovation and development.

The chief executive was due to retire in July 2019 and the trust had appointed a new chief executive from a neighbouring London trust due to start in July 2019.

The non-executive directors had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills such as finance and investment, strategic development, research, population health, working in partnership and

transforming services. The previous chair had identified through the completion of a board skills analysis, that they would benefit from more knowledge on estate management to support the ongoing estates strategy. The board and committees completed annual reviews to evaluate its effectiveness and make recommendations for improvement.

The executive board had one (17%) black and minority ethnic (BME) members and two (33%) women. The non-executive board had two (25%) BME members and four (50%) women. The non-executive directors were supported with their learning and development in line with a competency framework. Recently appointed non-executive directors had completed an induction process, which was tailored to their individual development needs and incorporated meeting key people and visits to gain an understanding of the work of the trust. A training needs analysis was completed for the board and in addition to mandatory training access to learning and development could be arranged as needed. This included access to external training on how to be an effective non-executive director. Each non-executive director had individual objectives and an annual appraisal. There were ongoing board development sessions and away-days.

All board members had lead areas including non-executive directors who chaired specific committees or were leads on areas of work. For example, one non-executive director provided links to Kings Health Partners for the academic and research work of the trust. Board members would attend each other's committees to understand their work and ensure issues that extended across more than one committee were considered in a joined-up manner.

The trust had very skilled and experienced executive directors who had a good understanding of their roles. The senior leadership team consisted of a chief financial officer, medical director, director of nursing, chief operating officer, director of corporate affairs, director of strategy and commercial and joint director of people and organisational development. The team had clear areas of responsibility including opportunities for individual development. The executive directors all had the support needed to give them capacity to undertake their roles.

The chair and chief executive worked with the governor-led nominations committee to actively consider succession planning. Future potential leaders in the trust were offered development opportunities to prepare them for more senior roles.

Arrangements were in place to ensure trust directors met the fit and proper persons' criteria. A random selection of trust board member fit and proper person checks were reviewed during our last well led review in August 2018. This showed that all the necessary checks had been completed including disclosure barring checks. Directors' checks are reviewed annually through a self-declaration.

Trust directors were found to be professional, to have integrity and to behave in a respectful manner towards everyone they met while performing their role. They demonstrated a high level of commitment to ensuring people who use services and their families received the best care and treatment possible.

The trust leadership team demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. People spoke with insight about the need to continue embedding the operating structures, to continue to work with external partners to meet the needs of the local population, to engage with and support staff and to embed quality improvement.

The trust board gained an additional understanding of the challenges of delivering services through a programme of board visits. For executive directors there were leadership walkabouts for quality and safety. At the last inspection, the trust had set itself an ambitious target of completing

250 of these visits a year to clinical and non-clinical areas and had nearly reached this target by the end of April 2019. Concerns from these visits could be discussed at a weekly executive directors' safety huddle. For non-executive directors, they could join the leadership walkabouts and a programme of joint visits with governors had also been restarted. The non-executive director visits were recorded, and the number of visits attended varied between directors. The chair accepted variability and had an expectation of a minimum of one visit a quarter. Issues from non-executive director visits would be escalated immediately after the visit through the director of corporate affairs and would feed into board discussions. During this inspection, staff said that senior leaders were more visible and accessible under the new operating structures.

Last year, the trust completed a restructure of its operational directorates into six new directorates. Four of these directorates aligned directly with the four boroughs. Each directorate had a service director working with a clinical lead and senior nurse.

At our last inspection, we found the trust needed to ensure leadership development opportunities were available for ward and team managers. During this inspection, we found the trust had made some improvements in this area. The trust had previously offered 'learning to manage' and 'learning to lead' training courses across the trust. At our last inspection, leadership development was being linked with the quality improvement training. The trust had also invested in a half day inclusive leadership course. This training using actors had been attended by 500 managers and supervisors with 300 still to attend and aimed to support leaders to promote equality, diversity and human rights. The three trusts in the South London Partnership were developing a leadership programme for band 7 nurses. Other bands of staff were also able to access some of the modules. More senior staff had been offered opportunities to access development through courses provided by the NHS Academy and other opportunities such as coaching or further academic opportunities. At this inspection the trust was working with SLAM partners, a team of organisational consultants and coaches and actors to deliver ongoing leadership training for staff.

Vision and strategy

The trust had developed a clear vision and set of five commitments which were known by staff.

The trust vision, commitments and strategic aims were visible and formed part of publications, such as the latest draft quality account and board assurance framework.

The trust had four quality priorities focusing on providing patient care, increasing service user and carer involvement, increasing staff satisfaction and reducing patient violence.

At our last inspection, we found the trust needed to complete the work in consulting and launching the refreshed strategy. During this inspection, we found the trust had completed this work. The trust worked with service users, staff and partners to contribute to the strategy. They published their new "Changing Lives" strategy in October 2018. They launched a film in January 2019 that set out the strategy and followed the journey of five service users and their clinicians. This strategy has five aims including: quality, partnership, a great place to work, innovation and value. The trust had a number of strategies sitting beneath the overarching 'Changing Lives' strategy looking at the specific areas for development. One key area for the trust was the estates strategy with plans to invest £175m over five years and to develop the Maudsley Campus. There was a quarterly estates update provided for the board.

The trust worked successfully and was well regarded within a very complex landscape across four London boroughs, four clinical commissioning groups and two sustainability and transformation partnerships. The leadership team was very committed to actively participating in the work and this formed a significant part of the chief executive's role. An example of how this collaborative work

was developing in practice was the active participation of the trust in the Lambeth Living Well Network. The trust was working in alliance with Lambeth clinical commissioning group, Lambeth council, Certitude and Thames Reach to provide a new model of care to deliver high quality mental health services in the borough. Similar work was progressing across the other boroughs. Another example of successful collaborative work was the development of the centralised health-based place of safety on the Maudsley site. This required collaborative work with the four boroughs to ensure approved mental health professionals were in place. The trust had also worked closely with the police and ambulance services.

The trust was working effectively with other NHS providers. A very significant development for the trust was the work taking place with the two other South London mental health trusts with the formation of the South London Mental Health and Community Partnership (SLP). The SLP was driving the work on delivering new models of care. Since April 2017, the SLP had been managing the budget for secure mental health services in South London and reviewing the forensic pathway to ensure there were adequate services available. Similarly, the partnership had been managing the budget for CAMHS across South London. These were leading to new models of care. For example, at SLAM a new eight bed adolescent psychiatric intensive care unit had opened in April 2018. This was contributing to fewer patients needing to be placed outside the South London area to receive care. There was clear evidence of collaboration in a range of areas with the aim of improving quality, learning from each other and sharing functions to maximise the use of resources. This included work on nurse recruitment and development.

As well as serving the communities in the four boroughs, the trust also provided over 50 specialist services for children and adults from across the UK. Some of the clinical and academic developments had international reach including Europe and the Middle East. The trust also had a partnership with the Institute of Psychiatry, Psychology and Neuroscience, Kings College London.

Culture

Staff were mostly highly motivated and wanted to provide the best possible care for patients. During the inspection most staff spoke positively about working for the trust and the support from their colleagues and managers. Many staff said that their experience at work and overall morale was linked to the quality of their immediate manager and the team they were part of. The previous inspection took place at a time of transition, with the management of services being reorganised. These had been further embedded at the time of our most recent inspections. Most staff understood and recognised the benefits of the reorganisation. However, they also said that they were very tired of the changes and were concerned about the ongoing work associated with agreeing the management structures within each directorate and the process of filling the individual posts. Whilst the trust used its communication and feedback channels throughout the consultation process, some staff did not feel they had received sufficient information about the changes. Some staff commented on the positive changes and improvements experienced since our last inspection.

The trust recognised that there was considerable ongoing work required to improve staff experience of working for the trust. The results of the NHS Staff Survey 2018 showed the participation rate of staff was 43%, which was below the national rate of 52%.

The following illustration shows how this provider compares with other similar providers on ten key themes from the 2018 NHS Staff Survey. Possible scores range from zero to ten – a higher score indicates a better result. In nine out of the ten areas, the trust was slightly below the average results for similar organisations.

The trust recognised the need to focus on its workforce and had a staff survey action plan. This was linked to their wider workforce plan monitored through the equalities and workforce committee which was a sub-committee of the board that met quarterly.

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts progress is monitored against nine measures of equality in the workforce. During the last inspection, we found the trust needed to take further steps to improve their result. During this inspection, we found the trust had made some improvements in this area but still had further work to do. The proportion of BME staff in bands 8A and above had improved and was 17.05% in 2015, 18.87% in 2016, 19.04% in 2017 and 20% in 2018. In 2018, white candidates were 1.61 times more likely than BME candidates to get jobs for which they had been shortlisted. The trust performance against this measure has improved from 1.93 times more likely in 2017. In 2018, BME staff were more likely to be disciplined, when compared with white staff and this had got worse when compared to previous years. In 2018, white staff were 0.63 times less likely to take part in voluntary training than BME staff.

The trust had put in place measures to understand and address concerns about discrimination and equal opportunities for career progression. The trust had an action plan in relation to the WRES and was developed collaboratively with staff from the BME network by the trust's 'snowy white peaks' working party. The action plan included diversity champions to sit on all recruitment panels for band 7 posts and above, providing inclusive leadership training for managers, introducing a development programme for BME staff, and the re-launch of a reflect and review checklist for managers to complete before deciding whether to take disciplinary action against a member of staff. The trust had trained 85 staff from the BME network to sit on recruitment panels. They had also recognised the need to ensure that all temporary posts requiring 'expressions of interest' would be advertised internally with a two-week period for registering interest. It was recognised that it would take time for staff to experience and feel confidence in the positive effects of the changes that were taking place.

During the last inspection, we found the trust needed to continue to support staff networks to ensure staff with protected characteristics have their dignity and human rights protected and promoted. During this inspection, we found the trust had made some improvements in this area. The BME network membership had increased and an LGBTQ and lived experience networks had been launched. Chairs of networks had access to a package of support including time to undertake the role, access to some funds and other facilities. The BME network had over 300 members and had actively contributed to the work to develop the WRES action plan. The network for staff with lived experience had recently been launched. The trust provided training for managers on how to support staff with lived experience, but staff said that the support from managers was currently mixed. The LGBTQ network was launched in July 2018. The trust provided staff with rainbow lanyards although more were needed. LGBT+ staff had given input to the trust's policy on caring for transgender patients. Staff thought the policy was good but difficult to find on the intranet. Some staff said it was difficult to be open about their sexuality in some teams, particularly where some staff were very religious and not accepting of homosexuality. They would like more training for staff generally and space within supervision to discuss issues. At the time of our inspection, the trust had just launched a lived experience staff network.

Most staff said that they felt able to raise concerns with their line manager without fear of retribution. The trust had a whistle-blowing process. Staff could raise concerns using an email or phone number. Between April 2018 and March 2019, only two formal cases had been raised.

The trust had a Freedom to Speak Up Guardian (FSUG) in place since 2016. At our last inspection, we found that the trust needed to continue to promote the work of the FSUG and ensure advocates are selected openly and offered training to perform their role. During this inspection, we found the trust had made some improvements in this area. More staff were familiar with this role, compared to when we inspected in 2018. The role was undertaken in around one and a half days a week by a director of organisation and community. Administrative support was provided. The FSUG had participated in training provided by the National Guardians Office. The FSUG had established a steering group. This consisted of ambassadors, a small group of senior staff who had responsibility for developing the function and ensuring it was carried out effectively. In addition, there were 16 advocates who were staff of different disciplines and levels who worked across the trust and were available to direct and help people wanting to speak up. The trust process for people applying to be advocates and being selected included several routes, for example, invitation to those who had used the service, nomination by management and responding to open advertisements. They accepted anyone who applied for the role. The trust had developed an induction for new advocates and some training. The FSUG reported formally to the board quarterly and provides and annual report. In 2018/19, the trust had 56 FSUG cases. The majority (42) of contacts related to behaviours including bullying and harassment. The FSUG was in the process of developing a policy that was in draft and due to go to the board in July 2019. The FSUG collected feedback on their performance and received feedback from 15 out of 56 contacts for the previous year, all of which were positive. However, there was no systematic evaluation of themes or learning from contacts.

The trust had a Guardian of Safe Working Hours, although this was relatively new and still being promoted using various medical forums across the trust. Whilst there had been a low level of reporting by junior doctors, one report was leading to a change in the rotas of some specialist trainees to ensure they had adequate breaks between shifts and another had led to a work-place

review. The guardian met with the other guardians from across the South London trusts at a network meeting every two months which promoted learning.

During the last inspection, we found the trust needed to continue to improve staff retention. During this inspection, we found the trust had made some improvements in this area, although staff vacancy and turnover rates were still high. The trust was looking at offering staff more flexible working conditions including compressed hours. They were also giving ward managers more support to develop their leadership skills with their teams. In December 2018, the trust had 32 trainee nursing associates and were recruiting 60 new ones in 2019. They were implementing a nursing development unit. The trust were reviewing their staff benefits, for example providing staff with study budgets to improve recruitment and retention.

The trust was making the most of opportunities to support apprenticeships. At the time of the inspection the trust had 89 staff on apprenticeship programmes. The largest groups were healthcare support workers and assistant practitioners.

The trust was making good progress with the completion of mandatory training. In July 2018 the completion rate trust wide of core subjects was 85.8%. Subjects which were below the trust target of 85% were monitored and where needed additional courses were being provided. Staff were reminded by email when their previous training was elapsing. Staff could not be rated at their appraisal as being satisfactory or above if they had not completed the mandatory training. More accessible venues for the training had been arranged. More training was being delivered by e-learning. The trust also acknowledged that the system which monitored the delivery of mandatory training did not consistently provide accurate data and work was taking place to address this.

The compliance for mandatory and statutory training courses at 31 December 2018 was 83% for the three core services that were inspected. Of the training courses listed 16 failed to achieve the trust target and of those, five failed to score above 75%. The trust set a target of 85% for completion of mandatory and statutory training, 95% for information governance and 100% compliance for PSTS Tutor training. The training compliance reported for the three core services during this inspection was higher than the 80% reported in the previous year.

The trust expected 95% of medical and 100% of non-medical staff to have an annual performance development review. The trust had introduced a new appraisal system.

This year so far, the appraisal rate was between 89% and 95% (as at 29 December 2018), for the three core services. The services with the lowest compliance were ‘community based mental health services for adults of working age’ with 89%.

Staff were largely positive about their access to managerial and clinical supervision, although on some wards this was not happening regularly. The trust was working to provide a system which monitored completion of supervision and supported managers to ensure supervision was delivered to all staff.

The trust had a health and well-being (HWB) strategy. This included access to an occupational health service, employee assistance programme and staff counselling service. The recent re-tendering of this service had resulted in the current service not having the capacity to meet the volume of referrals. This was being addressed. A critical incident support service provided support to teams following a serious incident. A number of initiatives were in place to support staff well-being. This included a health promotion game to be used by teams to think about how their well-being could be improved. There was also a mobile optician who came to the main sites; walking groups; portable desks for stand-up meetings; and access to physiotherapy. The HWB work was being promoted at staff inductions.

The trust recognised staff success. There were monthly awards and an annual awards ceremony. This was popular with staff throughout the organisation. A new celebration had been introduced for staff who had worked for 20 years for the trust.

Duty of Candour was being applied across the trust and guidance was in place. A review of three randomly selected root cause analyses following a serious incident showed that staff had liaised appropriately with the patients and relatives and they had received an apology. They had been offered support and asked to contribute to developing the terms of the investigation. The investigation process would identify if the Duty of Candour had not been applied and where staff needed additional support to undertake this in practice.

Since August 2016 all providers of NHS care have needed to follow the Accessible Information Standard (AIS) in line with section 250 of the Health and Social Care Act. The standard applies to people using services (and where appropriate carers and parents) who have information or communication needs relating to a disability, impairment or sensory loss. At our last inspection, we found that the trust needed to work on embedding the accessible information standard with staff. During this inspection, we found the trust had made some improvements in this area. The trust had a target to improve staff completion of the field to 30% by March 2019 and to 100% by March 2021. As of May 2019, the trust was currently at 28% completion. There were plans in place to add a flag to the patient record by the end of 2018, which would signal to staff patients' accessible information needs. The trust intranet provided guidance to staff on what they needed to do in terms of meeting the AIS and an e-learning module for staff was in development.

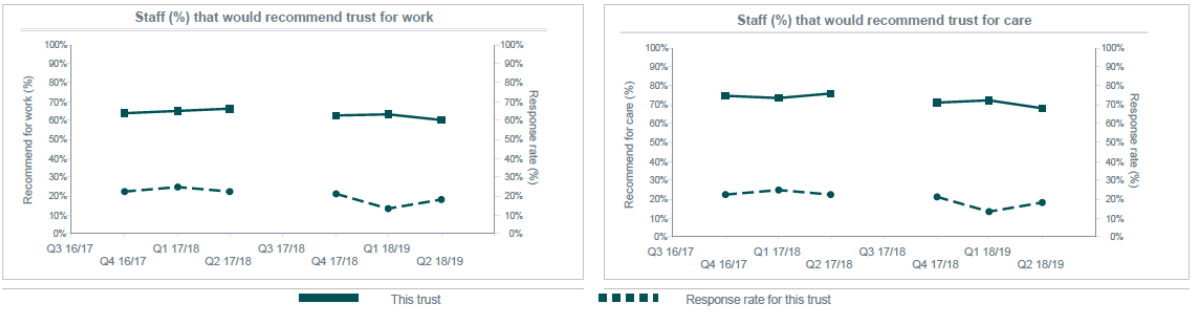
Managers were aware from completed patient experience surveys that patients who were deaf or had a visual impairment were less likely to report that services met their needs than patients without these impairments. Information leads were working to improve the overall quality and accessibility of information provided by the trust, whether in written format or through the trust website, including using new technology. The trust had provided British Sign Language interpreters on 280 occasions in the last year to help staff and deaf patients communicate more effectively.

The Patient Friends and Family Test asks patients whether they would recommend the services they have used based on their experiences of care and treatment. The trust scored between 2% and 8% lower than the England average for patients recommending it as a place to receive care for all the six months in the period (August 2018 to January 2019). The trust was higher than the England average in terms of the percentage of patients who would not recommend the trust as a place to receive care in all the six months.

	Trust wide responses				**England averages**	
	Total eligible	**Total responses**	**% that would recommend**	**% that would not recommend**	**England average recommend**	**England average not recommend**
January 2019	33,560	675	83%	5%	90%	3%
December 2018	33,610	784	83%	7%	89%	4%
November 2018	33,831	604	81%	8%	89%	4%
October 2018	33,719	1,424	88%	4%	90%	3%

	Trust wide responses				England averages	
	Total eligible	Total responses	% that would recommend	% that would not recommend	England average recommend	England average not recommend
September 2018	33,823	695	88%	5%	90%	4%
August 2018	34,296	613	82%	7%	90%	3%

The Staff Friends and Family Test asks staff members whether they would recommend the trust as a place to receive care and to work. The percentage of staff that would recommend this trust as a place to work in Q2 18/19 decreased when compared to the same time last year. The percentage of staff that would recommend this trust as a place to receive care in Q2 18/19 decreased when compared to the same time last year.



Please note: Data is not collected during Q3 each year because the Staff Survey is conducted during this time

Governance

The trust had structures, systems and processes in place to provide assurance and deliver the trust's key programmes. This included sub-board committees, and committees at a directorate and team level. The inspection took place after a borough based operating structure had been implemented when the associated systems and processes were still being embedded. This change had been carefully considered and as well as providing closer working with partners in boroughs it also reduced the span of control and provided more visibility and support for local services especially on the acute pathway.

The board operated effectively. The board met monthly and was well attended. The agenda was structured and there was a programme to bring topics to the board throughout the year. The papers for the board had an executive director sponsor and a clear summary. Each meeting always included a discussion about the latest finance and performance report. The topics discussed in the confidential part two of the board meeting were appropriate. The meeting was well chaired and board members provided constructive challenge. Following the previous inspection some non-executive directors had become more operationally focused whilst improvements were being made. This had been recognised and they were being supported to move back to being more strategic. The agenda at the board was tightly packed which meant that discussion of specific topics was brief, but non-executive directors said there were opportunities for more detailed discussions at sub-committees and other forums. The board completed an annual published review which included getting feedback from board members. This had led to improvements in the quality of the board papers and informed the skill mix of the board.

There were seven sub-committees of the board. These were audit, remuneration, Mental Health Act law, quality, equalities and workforce, business development and investment, finance and

performance. Each committee had terms of reference agreed by the board. Non-executive directors were clear about their responsibilities in terms of chairing and attending the sub-committees. They worked hard to ensure there was an appropriate level of communication between the sub-committees. For example, the chair of the quality committee was also a member of the audit committee. The committees produced a summary for the board and understood the issues that needed to be escalated.

At our last inspection, the directorate leadership teams attended separate quality and performance meetings to provide oversight of their work. Since November, the trust combined the executive quality and performance committees and the associated reporting to the board.

At a ward and team level front line managers were clear about their responsibilities. Each ward and team manager had access to a range of information containing essential performance information for their team. This helped to inform the management of their service.

At our last inspection, we found the trust needed to identify and provide timely support to wards and teams where standards of care needed to improve. During this inspection, we found the trust had made some improvements. The trust had increased the number of matrons in place from six to 11. They planned to have 16 matrons for the acute services, one matron for every two wards. The trust had also put coaching in place for managers and consultants where they required additional support. The trust anticipated that the new structures with reduced spans of control and access to more professional support would continue to improve standards of care across the wards and teams. Senior staff in the directorates and trust said that they knew that in wards or teams who were performing well, the manager and lead consultant had a good working relationship and addressed challenges together. They also knew where this was not happening in practice but acknowledged that more could be done to address this.

At the last inspection, we found the trust needed to ensure they understood and implemented fundamental standards of care across the trust. This included ensuring patients always had a bed when receiving inpatient care. We found significant improvement in this area, at the most recent inspection of acute and PICU wards, and far better systems for reporting and escalating, when patients on leave returned to a ward without notice, after their bed had been filled. The trust had better oversight and informed the board and CQC of the few occasions where a bed was not available for a patient.

At the time of the previous inspection the quality governance committees across the directorates and teams did not make use of standard agendas to ensure these meetings took place consistently. Some teams did not have regular meetings and in some cases members of the team were not invited to attend the meeting. Consistency and frequency of staff meetings had improved significantly at the most recent inspection although there were still a few areas where further progress was needed.

Medicines optimisation was well integrated into the governance structure for the trust. The department had a clear vision and regular audits provided assurance that it was operating effectively. The pharmacy department had a visible director. The trust medication safety officer was also the deputy director of the pharmacy and worked as a clinical pharmacist. Pharmacy staff were aware of all medicine risks. Quarterly reports were provided to the trust medicines safety committee. Medicines reconciliation data was very good. The trust completed medicines reconciliation for over 80% of admissions within 24 hours, and 100% of admissions within 72 hours. Staff had autonomy to conduct research and were encouraged to be innovative. A gap was identified in the pharmacy service provision to the community mental health teams. A business

case had successfully obtained funding for clinical pharmacists to specialise in this area. The trust planned to implement electronic prescribing by 2020.

There were robust arrangements to make sure that hospital managers discharged their specific powers and duties according to the provisions of the Mental Health Act 1983 (MHA). The use of the MHA and Mental Capacity Act (MCA) was overseen by the Mental Health Law Committee that met quarterly. Each borough had a MHA Forum that could report or escalate issues to the Mental Health Law Committee. The committee reported to the board and to the quality compliance committee. A quarterly report was produced by the committee. There was an executive and non-executive MHA lead at board level.

There was a head of MHA legislation who managed the MHA administration function in the trust, supervising the MHA administration team leaders and overseeing the four MHA administration teams, the floating team, the MCA and Deprivation of Liberty Safeguards (DoLS) team as well as the associate hospital managers hearings team. There was a clinical lead for the MHA and a clinical lead for the MCA who sat on the Mental Health Law Committee which also had service user representation. Recent issues discussed at the Mental Health Law Committee and reported to the board included late delivery of Mental Health Tribunal reports, the quality of reports, delays and cancellations of assessments under the MHA and the trust's response to CQC MHA review visits. The trust developed an MHA dashboard which would better enable the scrutiny and analysis of trends and performance.

The trust had a head of social care who was responsible for liaising with the four boroughs, including scrutiny of the approved mental health professional (AMHP) provision and function.

The trust also had an MHA and MCA training lead who was responsible for updating and disseminating policies. MHA and MCA training were mandatory for all clinical staff. Training included classroom teaching and e learning modules. There was an MHA and MCA training lead and the clinical leads for the MCA and MHA were also closely involved. We were informed that 80% of clinical staff had completed MCA training and 82% had completed MHA training, in line with the set targets.

The MHA administration team completed a register which detailed all the timeframes in relation to detention under the Act. Reminder notices were sent to each ward or community team, followed up by phone calls. We were told that breaches were low in number. Regular audits were undertaken including section 132 rights and assessments of capacity to consent to treatment and admission. We were told that there was a quality improvement project underway in relation to ward duties in respect of the MHA.

The CQC MHA reviewer visits continued to raise concerns with the consistency of the timely completion of assessments of capacity to consent to treatment upon admission and at regular intervals afterwards. This was the responsibility of the treating clinician and such assessments should be easy to locate on the recording system. The repetition of an explanation of rights was another issue that reviewers had identified several times. Such explanations could be recorded via an uploaded form, an entry in the progress notes or as a goal in care plans. Finally, there was significant variety in the involvement of patients in the review of their care plans. Some excellent examples of care plans were found across the services, and the recording of assessments of capacity on Hayworth ward was found to be exemplary.

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

	In Days	Current Performance
What is your internal target for responding to* complaints?	3	92%
What is your target for completing a complaint?	25	25.30%
If you have a slightly longer target for complex complaints please indicate what that is here	N/A	N/A

* Responding to defined as initial contact made, not necessarily resolving issue but more than a confirmation of receipt

**Completing defined as closing the complaint, having been resolved or decided no further action can be taken

	Total	Date range
Number of complaints resolved without formal process*** in the last 12 months	370	01/02/2018 to 31/12/2018
Number of complaints referred to the ombudsmen (PHSO) in the last 12 months	2	01/01/2018 to 31/12/2018

**Without formal process defined as a complaint that has been resolved without a formal complaint being made. For example PALS resolved or via mediation/meetings/other actions

The three core services received 68 compliments during the last 12 months from 1 January 2018 to 31 December 2018. This was higher than the 55 reported at the last inspection. 'Community based mental health services for adults of working age' had the highest number of compliments with 62% (42), followed by 'Acute wards for adults of working age and psychiatric intensive care units' with 35% (24) and 'Long stay/rehabilitation mental health wards for working age adults' with 3% (two).

Management of risk, issues and performance

The trust had systems in place to report risks and ensure these were being addressed. The trust had a risk register. Wards and teams could escalate risks to put on their directorate risk register.

The top corporate risks were on the board assurance framework (BAF). This had taken time to develop and was integrated into the high-level governance of the trust. It was clear who were the leads for each risk and which committees were monitoring the controls including the actions being taken to address the risk. The board and senior leadership team could clearly articulate the areas of risk. The monitoring of how risks were being addressed was appropriate. Also, the workforce challenges had led to the development of the workforce and equalities sub-committee of the board so that progress in addressing this work could be monitored. Risk two on the BAF clearly reflected the potential risks for patients accessing services on the acute pathway and this was one of the top three risks for the trust. It identified how this was being monitored through the trust performance report. It identified how the risks were being managed through the restructure of the trust to a borough-based model and the use of QI but that these benefits had not yet been fully recognised.

The trust recognised the importance of having a strong programme of quality assurance. The quality and performance committee received on-going feedback on several areas for example safeguarding, infection control, ligature reduction work, patient experience, carer engagement and support, physical health, compliance with NICE guidelines, safer staffing and CQC compliance. Some of these areas were trust wide and some were specifically in relation to a type of service

such as those in the acute pathway. This assurance work fed into the quality updates and performance and finance report at the board. This provided a summary of the key issues.

The trust participated in 100% of all the relevant national audits (seven in total) and in the one National Confidential Inquiry. There was an annual programme of clinical audits with about 15 trust-wide audits including safeguarding, user involvement, MHA / MCA, patient participation in research, and data quality. Records of actions taken were identified. The trust had introduced a new audit looking at the quality of individual patient risk assessments as this was a consistent theme in serious incidents.

Many clinicians at the trust were actively involved in research and the development of new clinical guidance. Systems were in place to ensure guidance used by the trust reflected NICE clinical guidance. This included an appropriate clinical lead completing a gap analysis for new and updated guidance. The clinical academic groups linked to the quality centre will support the development of improvement plans.

Appropriate staff recruitment checks were in place. The trust had implemented a system to ensure staff did not start working until all the necessary checks had been completed. This was checked at the previous inspection for ten randomly selected members of staff and the systems were thorough and working effectively.

Systems were in place to ensure medical revalidation was taking place. A trust revalidation advisory group was formed in May 2017, chaired by the medical director. Revalidations were being completed as planned unless the doctor was on prolonged leave or a new starter. Over the appraisal cycle 2017-18 the trust made 13 positive recommendations with seven deferrals and no non-engagement notices issued. An annual report was presented to the board. Nurse revalidation was also monitored. Each month nurse registrations are checked and if a person's registration had expired an email was sent to the employee with the lapsed registration, their line manager and the head of human resources. The employee was advised that pay was suspended due to the lapsed registration. The employee was also provided with a copy of the screen shot of the Nursing and Midwifery Council website providing confirmation of the lapsed registration and the reason for the lapse.

The trust had appropriate measures for safeguarding in place. The work was monitored through the trust safeguarding committee which met quarterly. Reports were submitted to the quality committee through to the board. The director of social care managed the safeguarding adult and children leads. There were safeguarding champions in each directorate. All the adult and children safeguarding training of each level had met the trust target of over 85% for relevant staff having completed the training. An annual safeguarding audit was completed across the trust. The numbers and types of safeguarding alerts were monitored. Work had taken place to promote safeguarding at the Bethlem Hospital where the numbers of safeguarding referrals were lower. The trust was experienced in dealing with 'prevent' cases and there was joint work with prevent coordinators and police.

Although there were estate development plans the trust was also aware of the need to maintain existing facilities. This was monitored through a capital estates and facilities dashboard bought to the trust board. This covered areas such as asbestos; electrical; fire; gas, legionella; and anti-ligature work. For fire safety they monitored the completion of fire alarm checks, equipment checks, fire risk assessments and fire safety audits.

In this last inspection, we found the trust needed to ensure adequate arrangements were in place for emergency planning and business continuity. At this inspection the emergency planning and business continuity arrangements had been updated and were now assessed as being a satisfactory standard.

The trust had effective systems for financial governance. At the time of the inspection, the trust made a surplus of £5.7m for 2018/19 with a surplus of £81k against the NHSI control total.

The trust completed community funding comparison work and found they were 17% below the London average. The trust was due to receive a 6.6% funding uplift from the four clinical commissioning groups for all its contacts for 2019/20. The trust planned to use these resources to invest in community services, CAMHS, perinatal and talking therapies (IAPT).

The trust was still spending above its budget for agency staff.

Organisations that report more incidents usually have a better and more effective safety culture than trusts that report fewer incidents. A trust performing well would report a greater number of incidents over time but fewer of them would be higher severity incidents (those involving moderate or severe harm or death).

South London and Maudsley NHS Foundation Trust reported more incidents from 1 January 2018 to 31 December 2018 compared with the previous 12 months. Death and moderate incidents increased from the previous year when compared to the current 12 months. Deaths increased from eight to 64 and moderate incidents increased from 336 to 1266.

Level of harm	**1 January 2017 – 31 December 2017**	**1 January 2018 – 31 December 2018 (most recent)**
No harm	3955	7558
Low	804	1046
Moderate	336	1266
Severe	26	23
Death	8	64
Total incidents	**5129**	**9957**

The Chief Coroner's Office publishes the local coroners Reports to Prevent Future Deaths which all contain a summary of Schedule 5 recommendations, which had been made, by the local coroners with the intention of learning lessons from the cause of death and preventing deaths. In the last two years, there have been seven 'prevention of future death' reports sent to South London and Maudsley NHS Foundation Trust.

Reducing violence and aggression was a trust quality improvement priority. The trust was using an approach called 'four steps to safety'. There were parts of the trust such as the forensic services where this approach was working well and there was reduction in violence and aggression and an associated reduction in the use of restrictive practices. However, on the acute wards, the implementation of the approach was varied and on wards where it had been used, some were not sustaining the improvements. The trust was determined to make this a success and had set realistic timescales, put in a stable appropriately skilled team to support the implementation of the approach, monitoring progress through weekly safety huddles, involving clinical directors and paired wards for support.

The trust had a reducing restrictive practices group, although this was being reviewed with the new operating structures to embed the work in each of the borough directorates. The number of patients restrained, and the level of prone restraints was monitored through the quality and performance committee. The numbers of restraints including prone restraints had reduced since December 2017. On the acute and PICU ward, since the last inspection in July 2018, the proportion of restraints that involved patients being restrained in the prone position had decreased from 54% to 39%. For the previous 12-month period, the number of incidences of use of rapid tranquilisation (645) had decreased from the previous 12-month period (753) for this core service. The trust had set itself a target as part of its quality priorities to reduce the number of restraints by 50% over three years and reduce prone restraint to zero in three years.

Systems were in place to ensure service users were having their physical healthcare needs met with a range of performance targets identified and monitored. The trust had a five-year physical health care strategy (2018-23) and progress was reported to the board. The key areas of focus were to reduce cardiovascular disease, respiratory disease and cancer as well as tackling the risks associated with dementia. Each directorate had a physical health committee and physical health leads. Staff were offered training on physical health awareness. The trust had core physical health standards which were the physical health checks and interventions they expected people using inpatient and community services to receive. These were monitored and in 2017-18 84% of inpatients completed the metabolic screenings (target was 90%) and 65% had the interventions; 41% of community patients were screened and 46% had interventions. On two wards they were using an electronic system to improve the delivery of this care called e-Obs. Staff were offered level 1 physical health awareness training and 74% of relevant staff had completed this. A deep dive into diabetes care took place in 2018, which was reported to the quality committee. Two pods for patients and staff to use in community teams in Southwark and Croydon and receive immediate results of key measures such as blood pressure, pulse, and body mass index had proved effective. The trust had been proactive in terms of health promotion, for example helping patients to stop smoking and addressing tobacco dependence. The percentage of patients who were smokers declined from 62% before the trust went smoke free to 52%. The physical health strategy contained a target of reducing the number of smokers by 30% by 2020. Other initiatives were taking place across the trust to support patients to live a healthier lifestyle.

Information Management

Staff at all levels of the organisation recognised that work was progressing to further improve the quality of the data they had available to perform their roles. Similarly, to all trusts there were a range of systems being used for patient records, reporting incidents, monitoring staff training along with many others. The trust knew which systems presented challenges in terms of data quality and where additional work was needed to ensure data accuracy, for example the system used to record staff training. Extensive work had already taken place to develop a trust data framework and trust dashboard linked to the new divisional structure. This had a soft launch in July 2018. The dashboard was user friendly and work was ongoing to incorporate relevant information from many of the databases used by the trust to create a single point of access. Staff were being supported to understand and use the dashboard through an internal online group and a weekly digital forum. Each page of the dashboard had a feedback button, so staff could easily report any problems.

At the last inspection, we found the trust needed to have effective systems in place to ensure information was shared consistently with wards and teams. During this inspection, we found staff

making good use of the new dashboard business information system. Managers throughout the trust could access relevant data trust-wide, at a directorate and ward and team level.

The trust had good information governance (IG) systems and processes in place. Staff received mandatory training in information governance. Training was also provided to new staff at the corporate induction. There had been 200 reportable information governance breaches in the previous year one of which was reportable to the information governance ombudsman. Most breaches related to administrative errors such as letters being sent to the wrong address or documents attached to the wrong record. The trust had prepared well in advance of the introduction of the General Data Protection Regulation. All new policies and innovations were privacy impact assessed. The trust submission to the annual NHS Digital Information Toolkit for 2016-17 demonstrated a 91% compliance with the standards. Assurance was presented to the IG committee and an annual report to the board. The head of information governance attended the London information governance managers' forum and chaired the south London Sustainability and Transformation Partnership (STP) information governance group, leading this work on behalf of the STP.

The trust has set up an information security committee. The trust was working with

NHS Digital as an early adopter of the digital cyber security programme. Progress was monitored through a cyber security dashboard. The trust had invested in security systems that met current regulations to protect systems from possible cyber-attack.

The trust recognised that staff continued to experience challenges with their use of information technology, with devices not working properly or confusing systems. The trust were replacing old devices. They were working to understand what devices and kit were most useful for staff to perform their work and we saw some teams using tablets in the community to access patient records and reduce the need to return to the base, and other teams who wanted to access to this technology to make their working lives easier. They were also trying to offer staff the guidance they needed to get the full benefit of the software systems they used.

The trust had some excellent examples of digital innovation. It had been awarded global digital exemplar status by NHS England in 2017 and had received £5m of funding to use digital transformation to make care more personalised and responsive to patient need. This included projects such as electronic observations which were being piloted, electronic prescribing and an electronic personal health record to digitally engage patients. The trust has recently invested in Perfect Ward to digitalise their internal audit system. They had piloted this in four services. The matrons and senior nurses helped to set the standards. The trust planned to have this fully rolled out to their inpatient and community services by the end of June 2019.

Engagement

The trust had many examples of positive engagement with patients and carers. The trust board meetings included hearing from a patient or carers about their experience.

Service users and carers were actively involved in aspects of the work of the trust. The trust had a patient and public involvement (PPI) strategy. There was a trust wide service user committee and a family and carer committee.

Across the trust there were PPI leads and a network of service user and carer advisory groups aligned to the operational directorates. These individuals and groups supported a range of trust activities. This included commenting on new service developments such as the design of the new health-based place of safety. They also contributed to the development of the trust quality

priorities. There were also examples of co-production work to improve information provided for patients. For example, in CAMHS young people had helped to review the first appointment card and to make a documentary for schools about the service.

The trust had an active involvement register open to people who use services, their friends, carers and families. Members could take part in up to 30 hours of activity a month and receive payment for their time. Arrangements were in place to help patients assess whether paid rewards would impact on their benefits.

In the November 2018 Community Mental Health Survey, the trust scored 6.6 out of 10 for patients having been involved as much as they wanted to be in agreeing what care they would receive, which was slightly below the national average.

The trust recovery college was delivering more than 60 courses in a term, with three terms per year. There had been more than 300 students per term over the previous five years.' All the courses were delivered jointly by a peer support worker and a health or social care professional.

People who use services were also actively involved in quality improvement projects and were part of the central team. There were QI projects focusing on improving patient engagement including one to improve the engagement with young people who use CAMHS through the use of social media.

The trust employed a small number of peer support workers. There were seven people employed in Lambeth, three in Lewisham and 11 in Southwark and none in Croydon, with 13 employed as trainers in the recovery college. These were all paid posts. The trust was looking to extend appointments as part of the introduction of new roles in community services.

The trust had 360 active volunteers and between 40-50% of the volunteers had lived experience of mental health issues. One volunteer coordinator focused on raising the participation of volunteers from a BME background. The trust offered a wide range of opportunities for volunteers to help with supporting activities, befriending, café assistants, gardening, reception work as well as many others.

The trust was active in and committed to improving the care experience of service users with protected characteristics, considering ways to make services more accessible and relevant and in supporting staff to provide person-centred care to all. For example, the trust analysed service user experience surveys in terms of the demographics of respondents to gain insight into the experience of patients with different protected characteristics. Key findings from 2017 trust-wide equality information included that most service users with protected characteristics reported positive experiences of care and treatment. In response to evidence suggesting that transgender patients frequently reported poorer experiences, the trust had developed a specific policy for supporting trans service users in CAMHS services. The trust was in the process of developing a formal gender identity clinical policy, building on the existing trust guidance for supporting adult transgender service users. The trust gathered input from transgender service users, carers, and stakeholders. The draft policy was due for ratification in July 2019. The trust had identified the need to improve sexual orientation monitoring to be able to monitor outcomes for LGBT+ patients more effectively.

Carers were also engaged in the work of the trust. The trust had a family and carers strategy. Carers' leads had been identified in each borough and there were carers' forums. Most teams had a carers' champion. Last year the trust had a quality objective for 75% of identified carers to have a carers engagement and support plan – but this was only achieved for 9.2% of carers. The routine identification of carers remained a problem and was a quality target. The trust provided a

families and carers handbook, carers' charter and arranged an annual families and carers listening event. Carers were encouraged to join the trust involvement register, to participate in quality assurance work for the trust. A quality improvement project focusing on carer engagement was underway in Lewisham.

The trust was working in partnership with local communities and organisations in the London borough of Lambeth to address issues of concern to the local BME communities. The trust was trying to replicate this way of working across all four boroughs. For example, a mental health awareness course for Black-led church leaders had been developed.

People who use services were asked to give feedback in a number of ways. The trust used a system where patients could use one of three methods to record their views: an electronic tablet, online URL links and paper surveys.

Governors were actively involved in the operation of the trust. They fed back that there had been significant improvements since the last inspection and that they found members of the board were very open, non-defensive, acknowledged the need to improve and there was a sense of mutual respect. They were able to perform their role of appointing and holding the non-executive directors to account. The council of governors was made up of 39 public, staff, service user, and appointed governors and there were quarterly meetings attended by many of the non-executive directors. There were governor working groups looking at quality; planning and strategy; bids; nominations; membership and involvement. These were attended by the relevant non-executive directors, so they could be asked about their work in each of these areas. The lead and deputy governor also had a quarterly meeting the chair. Governors observed the board meetings and participated in sub-committees. Governors met with the NEDs prior to the board meeting so questions could be asked relating to the papers. All new governors had access to an induction designed for governors, formal training for governors and also governor away days. Governors felt well engaged with the work of the trust. Only one visit to services had taken place in the last six months, but these were restarting at the time of the inspection. They did feel that their involvement in some strategic developments such as the new directorate structure could have taken place at an earlier point. The work of the governors was reviewed on an annual basis via a survey and the themes are pulled together.

The trust had over 14000 members who were kept in touch with the work of the trust through a monthly newsletter, were invited to members' events, and were asked to participate in surveys and consultations about plans for the trust. Governors who were supported to arrange the members' events did note that the attendance at these events could be low.

The trust recognised the importance of engaging with staff. A key approach for ensuring staff engagement was regular leadership walkabouts for quality and safety. One of the aims of these walkabouts was to develop a culture of open communication and safety, help solve concerns and share knowledge and learning. The trust was also in the process of updating the intranet which should be launched in the autumn. There was also the trust E-news which was read by over 50% of the staff. They also made use of social media with trust and individual accounts.

The trust had arrangements in place to work with staff including a joint staff committee with trade unions. Trade union representatives described how senior staff were generally responsive to issues raised by them. At the last inspection they did not feel they had sufficient facility time to complete all this work. At this inspection there was ongoing work with the joint director of people and organisational development to prioritise their work ensure adequate resources were available.

External stakeholders such as clinical commissioning groups fed back about the trusts engagement and said they felt the communication with the trust had improved and hoped that with the borough structures in place this would further enhance the feedback and collaborative working.

Learning, continuous improvement and innovation

The trust was keen to ensure that the move to a borough based organisational structure did not result in the loss of the positive aspects of the clinical academic groups. They were developing a quality centre to develop and commission quality standards for the operational directorates to implement as part of their pathways with clear outcomes. They were also ensuring that education and development along with research was supporting clinical development in the operational directorates. At this inspection, it was recognised that this was still in development and learning across the services was still an area for further improvement.

Over the last three years, the trust had invested in its quality improvement (QI) programme across the organisation. At the time of the inspection there were just over 100 QI projects. Over 1000 staff had received a range of training. A central QI team was in post consisting of a manager, QI leads for each directorate, QI coaches who were coming into post, two part-time patient and carer leads and analytical and administrative support. They developed an online QI toolkit although staff were saying they found the tools hard at times to use. A QI on-line micro-site was still in development which meant it was not possible for teams doing QI work to look at other projects. During this inspection, we found numerous examples of QI projects across the services we inspected. Staff could demonstrate how learning from QI projects had improved service delivery and patient care.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed.

The table below shows services across the trust awarded an accreditation and the relevant dates.

Accreditation scheme	Core service	Service accredited	Comments and Date of accreditation / review
AIMS – PICU (Psychiatric Intensive Care Units)	Acute wards for adults of working age and psychiatric intensive care units	Eileen Skellern 1 Ward (Southwark)	No date. Eden Ward (Lambeth) are engaged with the scheme but have not yet achieved accreditation.
AIMS – Rehab (Rehabilitation wards)	Long stay/rehabilitation mental health wards for working age adults	Tony Hills Unit (Lambeth)	No date. Westways has completed stage 1; peer review (Croydon). Heather Close has completed stage 1; peer review (Lewisham)
Centre for Quality Improvement	Perinatal Services	Mother and Baby Unit	Accredited 2017

The trust made the most of its close links with the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) and the dean of the IoPPN was a member of the trust board. The two organisations worked together to establish excellence in research and the best possible treatment and care for people with mental illness.

The trust had a research and development strategy, which set out research priorities. The research and development committee met quarterly. The committee membership was multidisciplinary and included professional and clinical academic group leads. Minutes from the research and development committee meetings were shared with the trust board along with an annual report. A risk assessment committee, with membership from SLAM and IoPPN oversaw potential risks arising from research projects. Kings Health Partners (a partnership of the trust, Guys and St Thomas,' King's College and King's College Hospital) oversaw the management of commercial studies and the risks involved.

The trust aimed to increase research capacity across all professional groups and promoted research as part of career development for staff. The trust was recruiting a nurse manager to develop the research capacity amongst nurses and setting key performance indicators for teams in terms of research. Small grants were made available to staff to conduct research projects at a ward/team level. Some of this money was used to support improved communications with staff and patients and raise awareness of research through the trust intranet.

The trust translated research findings into tangible benefits for patients. For example, a trial of a manual-based approach to the treatment of anorexia nervosa, resulted in this being recommended as the first line treatment by NICE in the eating disorder guidelines in 2017. In addition, the perinatal research team had developed an antenatal depression guided self-help intervention, which had been launched at perinatal network events. It was being used by many Improving Access to Psychological Therapies services across England.

Service users were encouraged to become involved in the research process through collaboration in the design, implementation and oversight of research. The trust had enrolled more than 15,000 patients and carers in 'consent for contact' or C4C, which enabled researchers to contact possible research participants directly to see whether they were willing to take part in projects. Services and teams advertised relevant research projects to service users and carers. The research and development committee was looking to increase the service user and carer voice through membership of the committee.

Looking forward the trust was very positive about the development work taking place to establish the Centre for Young People in collaboration with Kings Health Partners. This will bring together research, education and clinical practice to provide a service to support young people with mental health needs.

The trust provided many innovative services and schemes that had achieved national and international recognition. For example, most recently a sensory room on a female psychiatric intensive care unit, Eileen Skellern 1 won project of the year award at the Design in Mental Health Award May 2018. The King's Health Partners Pathway Homeless Team, which provides holistic and integrated care to homeless people, won Highly Commended in the mental health category BMJ awards. The National Adult Outpatient Neurodevelopmental Clinic at Bethlem Royal Hospital won the Award for Outstanding Health Services at the National Autistic Society's Autism Professionals Awards in March 2017.

The medical director was the trust lead on learning from deaths with a non-executive director providing oversight. The overall process was monitored through a trust wide mortality review group and mortality review committees in each directorate. Three reports a year went to the board and an annual review. The learning from deaths was linked to the development of a mortality reduction strategy. External reviews of deaths had been commissioned where needed. The trust had staff who were trained to use the review process for people with a learning disability.

Mental health services

Acute wards for adults of working age and psychiatric intensive care units

Facts and data about this service

The South London and Maudsley NHS Foundation Trust provides acute mental health services in four London boroughs: Southwark, Lambeth, Lewisham and Croydon. The trust serves a local population of 1.3 million people. The acute care pathway consists of 17 inpatient acute wards and four psychiatric care units (PICUs) based at four hospitals. Staff in the acute referral centre review and manage all referrals for admission to an acute ward or PICU in the trust.

As part of the inspection we visited the following wards:

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Bethlem Royal Hospital	Fitzmary 1	14	Female
Bethlem Royal Hospital	Gresham 1	20	Female
Bethlem Royal Hospital	Gresham 2	20	Male
Bethlem Royal Hospital	Tyson West 1	17	Male
Bethlem Royal Hospital	Croydon PICU	10	Male
Lambeth Hospital	Rosa Parks	18	Mixed
Lambeth Hospital	Luther King	18	Male
Lambeth Hospital	Nelson	18	Female
Lambeth Hospital	Eden PICU	10	Male
Lambeth Hospital	LEO Unit (Early Intervention)	18	Mixed
Ladywell Unit	Clare	17	Male
Ladywell Unit	Virginia Woolf	16	Female
Ladywell Unit	Powell	18	Male
Ladywell Unit	Wharton	18	Female
Ladywell Unit	Johnson Unit (PICU)	10	Male
Ladywell Unit	Jim Birley Unit	16	Female
Maudsley Hospital	Aubrey Lewis 3 (AL3)	18	Male
Maudsley Hospital	John Dickson	20	Male
Maudsley Hospital	Aubrey Lewis 2 (AL2)	18	Female

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Maudsley Hospital	Eileen Skellern 2 (ES2)	19	Male
Maudsley Hospital	Eileen Skellern 1 (PICU)	10	Female

Is the service safe?

Safe and clean care environments

Safety of the ward layout

At the last inspection in July 2018, several wards had not completed environmental risk assessments thoroughly or, where risks had been identified, had not mitigated them adequately. Some wards had failed to include the use of plastic bin bags in bathrooms, blind spots, and ligature points in their environmental risk assessments. At this inspection, progress had been made, but there was still room for improvement. All wards had completed up-to-date environmental risk assessments and staff completed hourly environmental checks of the ward environment. Staff we spoke with were aware of the risks around the wards and how to mitigate them. The service ensured new staff members, students and bank/agency staff were aware of the ligature points on the ward by including pictures of ligature points in their induction packs. In addition, staff discussed ligature anchors points in their monthly ward clinical governance meetings.

However, the use of plastic bin bags in communal areas across the acute wards was not consistent. Some wards did not permit plastic bags on the wards, whereas other wards still used plastic big bags in communal areas such as the dining room, garden and bathrooms. On Luther King Ward and Nelson Ward, staff had not identified the use of plastic bin bags in the communal areas on the environmental risk assessment. This was raised with managers during the inspection who confirmed that wards should not be using plastic bin liners. It was not clear in the trust's ligature anchor point policy if plastic bin liners were a banned item.

Not all environmental risk assessments had timescales for identified work that needed to take place, and it was not always clear who was going to take responsibility for these actions. For example, on Leo Unit, the ligature risk assessment from December 2018 had identified that work needed to take place on the ward, but there was no clear timescale for when this work was going to take place.

Most wards recorded comprehensive fire safety checks each month covering checks of fire doors, fire safety equipment, alarm systems and signage. Each ward carried out a fire evacuation four times each year.

The layout of many wards did not allow staff to observe all parts of the ward. However, on most wards, staff sufficiently mitigated the risks that this presented. For example, on many wards, the service had installed convex mirrors at most blind spots to mitigate the risks presented by poor visibility. Staff conducted hourly observations of each ward and placed high risk patients on enhanced observations. At the last inspection, some wards had not included blind spots on the environmental risk assessment of adequately mitigated the risk of blind spots. At this inspection, improvements had been made. For example, on Powell Ward and Virginia Woolf, the trust had installed additional convex mirrors to address blind spots.

There were potential ligature anchor points on all wards. Staff had taken steps to mitigate the risks of ligature anchor points by completing an annual ligature audit of each ward. Staff we spoke with were aware of the ligature risks on the ward and how to mitigate these.

The wards complied with guidance on eliminating mixed-sex accommodation. All wards except Rosa Parks Ward and Leo Unit provided single sex accommodation. On these wards, bedrooms for male and female patients were situated on separate corridors. Between 1 February 2018 and 31 December 2018, there were no mixed sex accommodation breaches for this core service.

On most wards, staff had easy access to alarms and patients had easy access to nurse call systems. On most wards, all members of staff carried personal alarms. Staff checked these alarms each time they were issued. However, on Virginia Woolf Ward, there were not enough alarms for staff and visitors. On Jim Birley Unit, staff told us that alarms were not working, and this was mitigated by using radios while they were being fixed, an order had been placed to replace the alarms.

Maintenance, cleanliness and infection control

At the last inspection in July 2018, some of the wards were not clean. Patients and carers told us they were unhappy with the cleanliness of the wards, especially in bathrooms and toilets. At this inspection, most wards were clean and well maintained, but a few of the wards were not clean. On Leo Unit, the communal female shower had a problem with the drainage of water, which resulted in a potent sewage smell. Staff said this had been reported to trust maintenance, but the issue remained yet to be solved. We raised this with the trust at the time of the inspection and they took immediate action to address the issue. At the Ladywell Unit, maintenance and cleanliness of the wards needed to improve. Staff said that toilets were often blocked on the wards. However, this had been escalated to senior managers and was identified on the risk register. Clare Ward was visibly unclean, and some walls displayed patient graffiti. On Virginia Woolf, three patients told us that there was not always toilet paper available. However, managers were aware of this and reminded staff of where extra toilet paper could be accessed. The most recent Patient-Led Assessments of the Care Environment (PLACE) assessment was carried out in 2018. Only the Bethlem Hospital achieved a score for cleanliness above the trust's average score of 98%. Only the Bethlem Hospital achieved a score for condition, appearance and maintenance above the trust's score of 95%. Lambeth Hospital scored 92%, the Maudsley Hospital and the Ladywell Unit scored 94%.

Ward areas were cleaned regularly. Cleaning services were provided by contractors. The trust monitored compliance with this contract. On most wards, cleaners worked on the ward from 7.30am to 7pm, delivered over two shifts; an early shift and afternoon shift which overlap and provide cover pre-breakfast to post-dinner time.

Staff followed infection control procedures, including correct handwashing techniques. Staff completed infection control audits to assess and monitor the risk of infection.

During our inspection, staff and patients told us that the Maudsley Hospital had experienced an infestation of mice. We raised this with the trust and they informed us that they were working with pest control agencies to manage the issue. Pest control agencies were visiting the wards every week to check the progress.

Seclusion room

None of the acute wards, apart from Tyson West 1, had a seclusion room. The Tyson West 1 seclusion room allowed clear observation and two-way communication, had toilet facilities and a visible clock. The seclusion room facilities followed the Mental Health Act Code of Practice.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff on most wards checked oxygen cylinders, ligature cutters, suction machines and defibrillators every shift. However, on Fitzmary 1 and Tyson West 1, staff did not store oxygen cylinders appropriately. The oxygen cylinders were kept loose and not strapped to the walls. Oxygen cylinders should be restrained in a cart or stand to avoid tipping or falling. This was raised with managers during the inspection.

Staff recorded checks of emergency equipment bags each week. Physical health examinations, such as electrocardiogram monitoring were carried out in treatment rooms. However, on LEO unit, we observed that staff carried out blood tests for a patient in the interview room as the treatment room was occupied. This was not best practice as the interview room did not have infection control or sharps disposable facilities.

At the Maudsley Hospital, staff did not know how to use the bolt cutters that were stored in the clinic rooms. There was a risk that if an emergency required the use of bolt cutters that staff would not know how to use them. This was raised with the trust during the inspection who informed us that they would put a training session in place for the use of bolt cutters.

At the last inspection in July 2018, in one hospital, the service had not anticipated the expiry date of some items of emergency equipment. This meant there was a delay in receiving replacements for items that had passed their expiry date. At this inspection, this was no longer an issue. Emergency equipment was well maintained and were within its expiry date.

Safe staffing

Nursing staff

At the last inspection in July 2018, there were high number of registered nursing vacancies on some wards. Staff turnover rates were above 25% on Rosa Parks Ward and Nelson Ward. Staff and patients on these wards told us that sometimes patients' leave was postponed or cancelled when staff were not available. At this inspection, although the trust had continued with their recruitment drive, staffing remained an issue. This core service reported an overall vacancy rate of 22% for registered nurses on 31 December 2018. The vacancy rate for registered nurses was higher than the 20% reported at the last inspection (2 July to 16 August 2018).

Managers reported that it was difficult to recruit into the nursing vacancies, despite the trust's increased recruitment drive. At the time of inspection, there were high number of registered nursing vacancies on some wards, including eleven vacancies on Leo Unit, seven vacancies on Nelson Ward, six vacancies on Rosa Parks Ward and five vacancies on Luther King Ward, Aubrey Lewis 2 and Clare Ward. The vacancies on Nelson Ward and Luther King Ward have since been recruited into, and six vacancies on Leo Unit have also been recruited into.

Staff told us the impact of high nursing vacancies was high use of bank/agency staff, low staff morale, supervision not always happening, and patients' leave sometimes being cancelled or postponed. For example, on Leo Unit, there were three band 6 registered nurse vacancies and eight band 5 registered nurse vacancies. This left one substantive band 6 registered nurse, and

three substantive band 5 registered nurses for an 18 bedded ward. Permanent staff said they felt under pressure to meet the demands of the ward and felt unsafe at times due to staffing. On Clare Ward, staff told us that they did not always feel safe on the ward due to the levels of staffing. Three patients told us that their section 17 leave was often cancelled or postponed. At the Maudsley Hospital, two staff members told us that sometimes leave had been cancelled. On the other wards, most staff and patients said leave was not often cancelled and was more likely to be delayed or postponed than cancelled. However, the service did not record incidents where staff shortages resulted in staff cancelling escorted leave or ward activities, so it was not possible for managers to understand or measure the impact of staff shortages on patient care and treatment.

Some wards had successfully recruited into nursing vacancies. On Tyson West 1, the manager had recently recruited into four registered band 5 nurse vacancies, and on Fitzmary 1, the manager had recruited to all five registered band 5 nurse vacancies. Managers told us that there was an on-going recruitment and retention campaign. The trust had started borough specific recruitment campaigns to attract staff to the services.

This core service had 78.3 (15%) staff leavers between 1 February 2018 and 31 December 2018. This was higher than the 10% reported at the last inspection (from 2 July to 16 August 2018). Nelson Ward reported the highest turnover rate of 33%, followed by Aubrey Lewis 2 (26%) in the last 12 months. Aubrey Lewis 3 reported the lowest turnover rate of 3% in the last 12 months.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Bethlem Royal Hospital	Gresham 1	32.1	4.0	15%
Lambeth Hospital	Nelson Ward	21.5	7.0	33%
Bethlem Royal Hospital	Tyson West 1	22.8	3.0	14%
Maudsley Hospital	ES1 Ward	30.0	4.0	15%
Maudsley Hospital	ES2 Ward	35.0	4.0	14%
Bethlem Royal Hospital	Fitz Mary 1	18.0	3.0	16%
Ladywell Unit	Jim Birley Unit	20.2	5.0	21%
Bethlem Royal Hospital	Gresham 2	27.4	3.0	12%
Maudsley Hospital	John Dickson Ward	30.5	3.0	11%
Maudsley Hospital	Ruskin Unit	22.1	6.0	26%
Ladywell Unit	Powell Ward	25.0	2.8	11%
Ladywell Unit	Clare Ward	23.1	2.9	13%
Ladywell Unit	Johnson Unit	28.3	0.0	0%
Ladywell Unit	Lewisham Triage	3.2	4.6	18%
Ladywell Unit	Wharton Ward	22.5	4.0	17%
Bethlem Royal Hospital	Croydon PICU	25.4	3.6	14%
Maudsley Hospital	AL3 Ward	26.1	0.6	3%
Lambeth Hospital	LEO Unit (Early Intervention)	26.0	3.5	14%
Lambeth Hospital	Rosa Parks	23.4	5.5	22%

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Lambeth Hospital	Luther King Ward	25.0	3.0	12%
Lambeth Hospital	Eden ICU	26.6	5.8	24%
Core service total		**514.2**	**78.3**	**15%**

The sickness rate for this core service was 5.1% between 31 January 2018 and December 2018. The most recent month's data (December 2018) showed a sickness rate of 4.6%. This was lower than the sickness rate of 6.9% reported at the last inspection (2 July to 16 August 2018). Wharton Ward and Rosa Parks Ward reported the highest average sickness rate of 7% in the 12-month period. John Dickson Ward reported the lowest average sickness rate of 2% in the 12-month period.

Managers had calculated the number and grade of registered nurses and healthcare assistants required. Each ward allocated three registered nurses and two healthcare assistants to early and late shifts. This reduced to two registered nurses and two healthcare assistants to night shifts. Some wards were piloting long day shifts during the time of inspection. This programme had had a positive impact on staff morale, retention and recruitment, and the trust were working on rolling this out to other wards.

The number of registered nurses and healthcare assistants did not match this number on all shifts. Between 1 February 2018 and 31 December 2018, 7% of nursing shift were not filled. This meant that some shifts did not have the required number of registered nurses. For example, on Leo Unit, between 24 March 2019 and 1 April 2019, out of 26 shifts, 17 shifts did not have the required number of registered nurses. On 24 March 2019, there was no registered nurse able to fill the shift. To mitigate this risk, an extra healthcare assistant was added to the numbers and the duty senior nurse on-site provided support. On Clare Ward, on one shift in February 2019, there were no registered nurses available for the shift. The ward manager stepped into nursing numbers to ensure there was qualified nursing input.

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. Between 1 February 2018 and 31 December 2018, bank staff covered 22% of nursing shifts and agency staff covered 5% of nursing shifts. The main reasons for bank and agency usage for the wards were due to vacancies and increased workload.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. Staff carried out a comprehensive induction checklist, which provided key information about the ward including health and safety and risk management. All ward managers reported that where possible regular bank and agency staff were used so that patients received continuity with their care.

Both unqualified and qualified staff were available in the communal areas on all the wards.

Patients told us that they had regular one-to-one time with their named nurse.

There were enough staff to carry out physical interventions safely. All the wards were based on large hospital sites with at least three other acute mental health wards. This meant that staff from other wards could quickly respond to requests for assistance if physical interventions were needed. Eighty-seven percent of staff were trained in promoting safe therapeutic services awareness and conflict resolution. This was above the trust's target of 85%.

Medical staff

There was adequate medical cover during the day and night and a doctor could attend the ward quickly in an emergency. Each ward had a team of doctors, led by a consultant, who were on duty during the week. Outside office hours, a duty doctor was available on each hospital site.

However, some wards did not have a permanent consultant psychiatrist. On Fitzmary 1, a full-time substantive consultant had not been in post for two years, although consistent locum consultant cover had been in place over this period. This post was being covered by a locum consultant who had only just started on the ward two weeks prior to the inspection. In the last six months, the ward had three separate locum consultant psychiatrists. In addition, Gresham 1, had not had a permanent consultant since January 2019. The clinical director for Croydon was covering the post for three days a week. The ward also reduced the number of beds from 20 to 17 to maintain patient safety. On Wharton Ward, there had not been a permanent consultant psychiatrist in post since September 2018, and this was being covered by a locum consultant. Recruitment had taken place, but the candidate withdrew in Feb 2019, recruitment was again underway.

Mandatory training

Most staff had received and were up-to-date with appropriate mandatory training. The compliance for mandatory training courses on 31 December 2018 was 83%. Of the training courses listed 13 failed to achieve the trust target (85%) and of those, three failed to score above 75%. Some staff had not completed mandatory training due to maternity leave or long-term sick leave. Some staff were booked to complete the training imminently.

Key:

Below CQC 75%	**Met trust target** ✓	**Not met trust target** ✗	**Higher** ↑	**No change** →	**Lower** ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Basic Life Support - Group 1	31	31	100%	✓	↑
Prevent Awareness	31	31	100%	✓	↑
PSTS Tutor	8	8	100%	✓	↑
Moving and Handling - Loads - Group 1	2	2	100%	✓	↑
Clinical Supervision	60	59	98%	✓	↑
Infection Control Level 1	48	46	96%	✓	↓
Smoking Cessation Level 2	26	25	96%	✓	↑
Fire Warden	226	212	94%	✓	↑
Safeguarding Children Level 3	74	69	93%	✓	↑
Safeguarding Children Level 1 and 2	478	436	91%	✓	↑
Dual Diagnosis - Level 1	270	244	90%	✓	↑
Moving and Handling - Patients - Group 1	21	19	90%	✓	↑
Moving and Handling - Patients - Group 2	413	370	90%	✓	↑
Equality, Diversity and Human Rights	509	452	89%	✓	↑
PSTS Team Work	437	389	89%	✓	↑
Moving and Handling - Loads - Group 3	73	64	88%	✓	↑
Clinical Risk	459	399	87%	✓	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
PSTS Awareness/Conflict Resolution	31	27	87%	✓	↑
Safeguarding Adults Alerters	31	27	87%	✓	↓
Safeguarding Children Level 1	31	27	87%	✓	↓
Prevent Workshop	478	411	86%	✓	↑
Fire Safety Awareness	509	434	85%	✓	↑
Health, Safety and Welfare	509	434	85%	✓	↑
Smoking Cessation Level 1	478	407	85%	✓	↑
Infection Control Level 2	461	387	84%	✗	↑
Mental Health Act Training	279	233	84%	✗	↑
Information Governance	509	420	83%	✗	↑
Safeguarding Adults Alerters Plus	478	399	83%	✗	↑
Mental Capacity Act (MCA)	295	244	83%	✗	↓
Deprivation of Liberty Safeguards (DoLS)	478	379	79%	✗	↓
ASCOM	480	375	78%	✗	↑
Basic Life Support - Group 2	208	161	77%	✗	↑
PSTS Disengagement	33	25	76%	✗	↑
Immediate Life Support	269	203	75%	✗	↑
NEWS	434	291	67%	✗	↓
Health and Safety for Managers	62	40	65%	✗	↑
MEWS	432	228	53%	✗	N/A
Core service Total	**9651**	**8008**	**83%**		

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at 59 care records during the inspection of the acute wards.

Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident. A summary of risks was included in the initial assessment. A full risk assessment was completed within 24-hours of admission. Risks typically included self-neglect, self-harm, poor physical health and violence and aggression. Most risks to patients were assessed, monitored, updated regularly and managed on a day-to-day basis. Individual risks were discussed in multidisciplinary meetings, individual reviews, handovers and best interest meetings.

Staff used a recognised risk assessment tool. Staff recorded risk assessments on a standard form within the electronic patient record. Staff entered details of the patient's risk history, current risk and a risk management plan.

Management of patient risk

Staff demonstrated an awareness of specific risk issues for patients. For example, staff completed food and fluid charts for patients whose weight was particularly high or low. Staff recorded blood sugar levels for patients with diabetes each day. Nurses reviewed patients' physical health needs using the national early warning score (NEWS). Staff completed falls risk assessments for patients with mobility issues.

Staff identified and responded to changing risks to, or posed by, patients. Across all sites, individual risks and changing risks were discussed in multidisciplinary meetings, individual reviews, handovers and best interest meetings. Some wards used the dynamic assessment of situational aggression (DASA) tool to monitor patients' risk, a nationally recommended evidence-based tool. Some wards used a red, amber and green zoning system for identifying patients' needs and interventions to reduce the overall risk to patients.

Staff undertook observations according to the policies and procedures of the trust. Patient observation levels were discussed and reviewed for their appropriateness as each handover and multidisciplinary team meeting. At the last inspection in July 2018, on Clare Ward, staff failed to record observations of a patient, who required intermittent monitoring, for a two-hour period. At this inspection, this was no longer an issue. Staff recorded observations of patients as prescribed by the multidisciplinary team.

Staff followed the trust policy when searching patients. Staff told us all patients were searched on admission and each patient's consent was sought for this process to take place as per trust policy. Patients were not routinely searched when they returned from leave. Patients that presented a risk of self-harming or bringing in prohibited items onto the wards had their bags searched.

Staff applied blanket restrictions on patients' freedom only when justified. Blanket restrictions that were in place were consistent with the need to provide a safe environment. For example, the service did not permit drugs, alcohol or sharp objects to be bought onto the ward.

Staff adhered to best practice in implementing a smoke-free policy. The service provided nicotine replacement therapy to patients on request. Staff could access additional support from the smoking cessation lead nurses. On Aubrey Lewis 3, the manager was in the process of applying for a grant to purchase smoking survival packs for patients which includes guidance on smoking cessation and self-help de-stress tools and techniques. However, we found that patients were smoking in the bathroom and toilet areas on Rosa Parks Ward, Wharton Ward and Powell Ward. Staff were working with patients to address this issue and reminded patients that smoking was not permitted on the ward.

Informal patients could leave at will and knew that they were able to do so. Each ward displayed a notice by the main exit doors stating that informal patients could leave if they wished to do so.

Use of restrictive interventions

This service had 1260 incidences of restraint (845 different service users) and 158 incidences of seclusion between 1 April 2018 and 31 January 2019. Nelson Ward had the highest number of restraints across the acute wards at 94, which involved 32 patients.

Since the last inspection in July 2018, the proportion of restraints that involved patients being restrained in the prone position had decreased from 54% to 39%. The Jim Birley Unit had the highest number of prone restraints across the acute wards at 46.

The below table shows the number of restrictive interventions used between 1 April 2018 to 31 January 2019.

Ward name	Seclusions	Restraints	Patients restrained	Of restraints, incidents of prone restraint	Of restraints, incidences of rapid tranquilisation
Clare	0	24	23	14 (58%)	13 (54%)
Aubrey Lewis 3, Maudsley Hospital	0	40	32	15 (38%)	20 (50%)
Croydon PICU, Bethlem Royal Hospital	35	81	55	26 (32%)	20 (25%)
Eden Ward (PICU), Oak House, Lambeth Hospital	19	36	42	9 (25%)	17 (47%)
Eileen Skellern 1, Maudsley Hospital	49	149	78	58 (39%)	71 (48%)
Eileen Skellern 2, Maudsley Hospital	0	36	28	13 (36%)	23 (64%)
Fitzmary 1, BRH	1	79	34	27 (34%)	53 (67%)
Gresham Ward 1, BRH	4	78	55	11 (14%)	27 (35%)
Gresham Ward 2, BRH	0	33	29	11 (33%)	15 (45%)
Jim Birley Unit, Ladywell Unit (Decanted from MH 28.08.15)	0	67	48	46 (69%)	49 (73%)
John Dickson Ward, Maudsley Hospital	0	48	40	21 (44%)	28 (58%)
Johnson PICU Ward, Ladywell Unit	36	71	54	24 (34%)	34 (48%)
Leo Unit, Early Intervention Unit (Lambeth Hospital)	3	54	34	19 (35%)	26 (48%)
Luther King Ward, Lambeth Hospital (Acute Inpatients)	0	38	33	13 (34%)	21 (55%)
Nelson Ward, Lambeth Hospital	1	94	32	27 (29%)	47 (50%)
Powell Ward, Ladywell Unit (Locality Ward)	2	75	35	32 (43%)	47 (63%)
Rosa Parks Ward (Lambeth Hospital)	1	29	26	17 (59%)	13 (45%)
Ruskin, AL2, Maudsley Hospital	2	35	26	23 (66%)	26 (74%)
Tyson West 1, BRH (Croydon)	2	67	45	15 (22%)	17 (25%)
Virginia Woolf Ward, Ladywell Unit	1	57	51	34 (60%)	31 (54%)
Wharton Ward, Ladywell Unit (Locality Ward)	2	69	45	32 (46%)	47 (68%)
Core service total	**158**	**1260**	**845**	**487 (39%)**	**645 (51%)**

At the last inspection in July 2018, staff were unaware of initiatives to reduce the level of prone restraint. At this inspection, improvements had been made. Staff were aware of the trust's 'Four Steps to Safety' initiative to reduce violence and aggression on the wards. This initiative aimed to encourage staff to be pro-active in managing risk, to engage with patients, to work as a team to manage risk, and to create a more therapeutic environment. In addition, some wards had taken part in the Safewards initiative, which looks at understanding conflict and containment on the wards. On Gresham 1, we saw a good example where staff used a self-soothe box with a patient who was at high-risk of self-harm. Staff had collaborated with the patient to put together a box of the patient's personal belongings that would help soothe them when they felt distressed.

Managers had access to the number of incidents of restraint and regularly reviewed them to monitor levels of restrictive practices. Most ward managers reported a decrease in violence and aggression and prone restraint incidents on the ward since the introduction of the provider's restrictive interventions reduction programme. For example, on Rosa Parks Ward, in February 2019, there had been three incidents of violence and aggression recorded, compared to November 2018, where ten incidents of violence and aggression had been recorded.

Staff used restraint only after de-escalation had failed and used correct techniques. Incidents involving restraint were recorded on the electronic incident reporting system. Records stated that staff consistently tried to de-escalate situations before using restraint. De-escalation involved staff talking to the patient, encouraging the patient to move to a quiet area of the ward and offering medicine prescribed on an 'as required' basis.

At the last inspection in July 2018, restraint records did not always record details of the holds used by staff during the restraint or the number of staff involved. At this inspection, this was no longer an issue. Staff recorded appropriate details of restraint, which included number of staff involved, type of restraint and lessons learned. However, staff did not record if the patient received a debrief following the restraint.

Staff understood and, where appropriate, worked within the Mental Capacity Act definition of restraint. Records of restraint included details of the circumstances that led up to the restraint. These records demonstrated that staff only used force or restricted patients' liberty to prevent harm to the patient. Records also demonstrated that when staff used force to restraint a patient, their action were proportionate to the likelihood and seriousness of harm.

There were 645 incidences of rapid tranquilisation over the reporting period. Rapid tranquilisation is when medicines are given through intramuscular injection to a person who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others and allow them to receive the medical care that they need. Incidences resulting in rapid tranquilisation for this service ranged from 13 to 71 per month over (1 April 2018 to 31 January 2019). The number of incidences (645) had decreased from the previous 12-month period (753).

At the last inspection in July 2018, staff did not consistently carry out and record physical health checks on patients following the administration of rapid tranquilisation. This was contrary to national guidelines and trust policy. At this inspection, improvements had been made. Most wards followed the trust policy and the National Institute for Health and Care Excellence (NICE) when using rapid tranquilisation. Nursing staff had received training in rapid tranquilisation and managers had oversight of the amount of rapid tranquilisation happening on the wards as staff reported them as incidents. Modern matrons completed monthly audits of rapid tranquilisation and followed up any concerns with ward managers. However, on Rosa Parks Ward and Nelson Ward, we found three records that did not demonstrate that staff carried out physical health checks on patients after they received rapid tranquilisation. For example, records did not demonstrate that staff offered to check patients' vital signs every 15 minutes for the first hour, as stated in trust policy.

Staff rarely used seclusion and tried to follow best practice when they did so. This usually involved a patient who was waiting for a bed on a psychiatric intensive care unit (PICU) to become available. As the trust did not provide seclusion rooms on most acute wards, staff usually secluded patients in their bedrooms. Bedrooms did not provide a safe environment that allowed clear observation and communication. The service attempted to mitigate these risks by ensuring the time patients were secluded in their room was kept to a minimum. For example, on Rosa Parks Ward in October 2018, a patient was secluded in their bedroom and transferred to a PICU three hours later.

Staff kept records for seclusion in an appropriate manner. For the seclusion on Rosa Parks Ward in October 2018, initial medical and nursing reviews took place within one hour.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had received training on how to recognise and report abuse and they knew how to apply it. Staff received training in both adults and children safeguarding level two and three.

Staff were aware of how to report a safeguarding alert and gave examples of referrals they had made. These included issues such as pressure sores, domestic violence, verbal and physical abuse and financial abuse. The trust had a safeguarding team where staff could refer safeguarding concerns or to obtain advice. The team had safeguarding officers who were available to attend the wards to support staff with safeguarding matters. Staff supported patients to liaise with other agencies such as courts and the local authority during their safeguarding investigations and beyond.

Staff followed safe procedures for children visiting the ward. All wards had access to family rooms which were off the main ward environment to facilitate family visits.

Staff access to essential information

Staff recorded information about patients on an electronic patient record. Incidents were recorded on an electronic incident record.

All information needed to deliver patient care was available to all relevant staff when they needed it and in an accessible form. Wards provided agency staff with a temporary user name and password to enable them to access the system. The system showed details of entries made by staff within the trust, including entries made during admissions to other wards and entries made whilst patients under the care of community mental health teams.

Staff across the acute wards reported that the electronic systems were slow at times.

Medicines management

Staff followed good practice in medicines management and did so in line with national guidance. Medicines were supplied by the onsite trust pharmacy dispensaries. Staff ordered, reconciled, dispensed and disposed of medicines safely. We saw that controlled drugs were stored and managed appropriately. Arrangements were in place to facilitate medicine supplies out-of-hours. Staff stored medicines securely. Medicines requiring refrigeration were stored appropriately. On most wards, staff monitored the temperature of refrigerators and clinic rooms where medicines were stored. However, on Aubrey Lewis 2, the temperature of the clinic room had occasionally been recorded at 27 degrees, and no action had been taken. This was above the accepted range of 25 degrees or less, and as a result could have impacted the effectiveness of the medicines.

Measures were in place to monitor when medicines would expire. However, on Wharton Ward, we found out-of-date medicines from January and March 2019. In addition, we found a medicine in the fridge that had been opened, but it was unclear which patient it was for and for how long it had been opened. Information on the medicine stated that it should be disposed of within 14 days. These issues were raised with managers on the inspection.

Medicines were appropriately prescribed and administered. However, on Gresham 1 we found a medicines error where a patient had received more than the prescribed dose over a 24-hour period. We informed staff of this during the inspection and they immediately acted and reported it as an incident.

Staff mostly reviewed the effects of medicines on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication or rapid tranquilisation. Records showed that staff carried out blood tests for patients receiving medicines that required monitoring such as clozapine and lithium. Pharmacists were aware of the patients who were on high dose antipsychotic medicines. During ward rounds, pharmacists discussed patients on high dose antipsychotics with doctors to ensure that the high doses were only prescribed if necessary and the minimum amount of time needed.

Track record on safety

Between 1 January 2018 and 31 December 2018 the service had reported 18 serious incidents trust to the Strategic Executive Information System (STEIS) at NHS improvement for the purpose of national learning. Of the total number of incidents reported, the most common type of incident was 'apparent/actual/suspected self-inflicted harm' with five. There were four unexpected deaths for this service.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and when to report them. Staff reported incidents on the trust's electronic reporting system. Incidents included self-harm, violence and aggression, medicine errors, and rapid tranquilisation incidents.

At the last inspection in July 2018, staff did not always identify and report patient safety incidents. Staff were not always aware of incidents from the service and across the trust, and the lessons learned from investigations into these incidents. At this inspection, we found that incident reporting and learning from incidents had improved across the acute wards. While we found two incidents had not been recorded on Aubrey Lewis 2, other incidents that we reviewed across the wards had been recorded appropriately.

Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong. Staff we spoke with were aware of the need to be open and transparent with patients and carers should things go wrong.

Staff received feedback and learning on incidents during handover, supervision, team meetings and in individual case discussions. For example, on Aubrey Lewis 3, staff implemented a cleaning task list to manage patients who presented with bedroom hygiene or incontinence issues to ensure that their bedroom was cleaned on a regular basis during the day.

Managers investigated incidents and shared lessons learnt with the whole team and the wider service. The trust circulated 'blue light bulletins' detailing incidents that had happened across other parts of the trust. For example, there had been a sharps bin injury on Fitzmary 1, and as a result, the trust sent a blue light bulletin to other wards alerting how to safely use the bins.

Staff were debriefed and received support after a serious incident. Staff explained that a debriefing was held with staff involved after an incident had occurred. This was recorded on the electronic incident record. After more serious incidents specialist staff attended the ward to facilitate a critical incident support session. This provided the opportunity for staff to reflect upon and learn from incidents.

Staff told us they received reflective practice with the psychologist to discuss incidents and that managers were very supportive.

Is the service caring?

Safe and clean care environments

Safety of the ward layout

The physical environments of the psychiatric intensive care wards were safe and fit for purpose. Any environmental risks which were present, including ligature anchor points and potential blind spots, were recognised by staff locally and managed through individual patient risk assessments. Ward areas used convex mirrors to mitigate risk presented by blind spots on the wards.

Each ward had a comprehensive environmental risk assessment and senior staff on site checked the ward environments monthly and completed audits of these visits to ensure that any outstanding issues were addressed in a timely manner. If any issues were identified during these checks there were governance systems in place to ensure they were followed up.

Staff we spoke with were aware of the key environmental risks on the ward. Staff induction, including induction for bank and agency staff, included information about the ward environment and any risks. Staff were able to tell us about the key environmental risks on the ward and had a good understanding of patient need.

At all sites, staff on the ward, and visitors to the ward had access to alarm systems which ensured that assistance could be requested if required. Staff tested the alarm systems to ensure they worked and staff responded appropriately to alarms.

At our last inspection in August 2018, we identified concerns around the safety of an area of the garden on Eileen Skellern 1 (ES1). During this inspection, we saw that environmental changes had been prioritised in this area and this issue had been addressed. This was an improvement.

Maintenance, cleanliness and infection control

Patients were provided with care in clean and well-maintained wards. Domestic staff had schedules in place to ensure that all parts of the ward were clean.

Staff across the sites told us that generally when repairs were identified, there were systems in place to ensure that they were completed in a timely manner, based on level of risk. However, some staff reported that repairs could be delayed when they were non-urgent. For example, staff on Johnson Ward in Lewisham told us that a staff computer had taken three months to fix. This meant that the risk identified by maintenance and repairs was addressed but there could be some improvements to the systems which followed non-urgent repairs.

We checked infection control audits on the wards we visited. We saw that all wards had updated infection control audits including hand hygiene audits and mattress audits. Staff were aware of basic infection control standards and requirements on the wards.

Seclusion room

Each Ward had a seclusion room. In these seclusion areas, patients could view a clock, communicate through an intercom with a member of staff and access toilet facilities. On Eden Ward in Lambeth, there was no shower available for patients in the seclusion room but these were present on the other sites.

Staff could observe patients who were being nursed in seclusion.

During our inspection, we identified some concerns regarding safety of the physical environment in the seclusion room on Eden Ward in Lambeth, these concerns were addressed immediately after the inspection by the trust. Further work is due to be completed on the ward.

Clinic room and equipment

Each ward had a clean and well-maintained clinic room. Equipment required to monitor the physical health of patients, for example, scales and blood pressure monitors were stored tidily and were regularly maintained and calibrated to ensure their accuracy.

Staff checked that emergency equipment and medicines were available and safe to use daily. We checked logs which indicated that these checks had been completed and we checked the equipment, including a defibrillator and oxygen were present.

Safe staffing

Nursing staff

		Registered nurses			Health care assistants			Overall staff figures		
Location	**Ward/Team**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**	**Vacancies**	**Establishment**	**Vacancy rate (%)**
Bethlem Royal Hospital	Croydon PICU	5.5	18.7	29%	1.8	11.0	17%	7.3	32.7	22%
Ladywell Unit	Johnson Unit	1.7	19.0	9%	0.0	10.0	0%	1.7	30.0	6%
Lambeth Hospital	Eden ICU	2.3	17.7	13%	0.8	10.0	8%	3.1	29.7	10%
Maudsley Hospital	ES1 Ward	4.4	17.4	25%	-8.0	11.0	-73%	-4.6	30.4	-15%

NB: All figures displayed are whole-time equivalents

At our last inspection in August 2018, we found that the total vacancy rate for registered nurses across the PICUs was 25%. At this inspection, we found that the total vacancy rate for registered nurses was 19%. There had also been a significant improvement in the vacancy rate for health care assistants. However, there were still areas where staffing was stretched, particularly registered nurses. Staff across the wards, but particularly on Eden Ward and Croydon PICU told us that registered nurses felt that there was pressure on the staff due to the staffing levels on the wards. This could have had an impact on quality of the delivery of care. For example, on Eden Ward, where there were three vacancies for nurses at band 6, there were low supervision levels. Staff told us that supervision had been impacted by the staffing levels on the ward. While work had continued to take place to manage nursing vacancies, this was an area where the trust needed to continue to ensure ongoing emphasis was taken to ensure that quality of care was maintained on the ward.

We checked the safe staffing figures between December 2018 and February 2019. We looked at staffing over early shifts, late shifts and night shifts. Out of 270 available shifts on each ward, there were 52 shifts where there were below the numbers of registered nurses required as a minimum number on ES1 and 47 on Eden Ward. While numbers of healthcare assistants was augmented to ensure safety on the ward, some shifts lacking sufficient registered numbers which meant there was a risk of impact on quality of care.

We asked the trust to provide us with information about the fill rate for registered nurses on the PICU wards for the six months prior to the inspection, between 1 November 2018 and 30 April 2019. On Eden ward, for qualified nurses (excluding the ward manager), the fill rate was an average of 78% in this period, for staff nurses (band 5 nurses) and 75% for charge nurses (band 6 nurses). This meant that there were significant gaps in the staff team. This included two months, in February and March 2019, where the fill rate for charge nurses was 50%. Staff on the ward told us that due to the absence of charge nurses, it was not consistently possible for all staff to receive regular supervision.

There were enough staff to carry out physical interventions (for example, observation, restraint and seclusion) safely and staff had been trained to do so.

Medical staff

Each ward had a dedicated consultant psychiatrist as well as ward doctors and doctors in training who provided medical cover to the ward during the day. Night time cover was provided through a rota system which meant that doctors were available to attend the wards in an emergency.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone had completed it. The mandatory training rate across the core service was at 83% compliance. Each ward manager had a record of the mandatory training levels on their ward and they were able to access this information to follow up with staff whose training was out of date.

Assessing and managing risk to patients and staff

Assessment of patient risk

We checked 15 care records across the service. All the records had comprehensive risk assessments which covered the key areas of risk and reflected the current risk information. Staff had a very good understanding of the risk levels of patients on the ward and were able to talk extensively and knowledgeably about the current risk on the ward.

Staff were aware of the need to be proactive in risk assessment and management in a way that met the needs and requirements of PICU.

Management of patient risk

Staff had undertaken a number of interventions in line with the ‘four steps to safety’ initiative which focussed on managing and mitigating risk in inpatient settings. One of the areas which we saw was embedded in ward practice was the use of dynamic assessment to situational aggression (DASA) tool. This is a collaborative tool to monitor and identify changing risk for each patient over a 24-hour period. This meant that risk was discussed within the team daily and any change in risk levels was identified clearly through ‘zoning’ which identified the patient as high, medium or low risk. Staff had a good understanding of the use of this tool and felt it helped them respond for flexibility to patient need based on risk.

We also saw that wards used intentional rounding which was another aspect of the four steps to safety. This was when staff ensured that there was an interaction with every patient at certain points during the day to ensure that all patients had the opportunity to share any concerns and issues, even if they were not actively seeking out members of staff. This was used as well, to identify any early stages of frustration or developing risks.

We saw in some care records that staff had adopted an approach on some wards to update using an SBARD format. This meant writing patient records in a way that recorded the situation, background, assessment, recommendation and decision. Using this format ensured that key information was consistently shared. This was being used on Johnson Ward and in Croydon but was still embedding in some of the other wards. All wards had records which reflected the key needs and risks of patients.

Staff had a good understanding of blanket restrictions and were working towards reducing any potential blanket restrictions on the ward. For example, in Croydon PICU, staff told us about a new project they were working on to allow patients access to a non-smart mobile phone. Patients were positive about this. Staff told us they felt this had led to a reduction in frustration expressed by some patients when waiting to use telephones.

At our previous inspection in August 2018, we saw that patients on Johnson Ward had restricted access to drinking water. At this inspection, we found that this was not the case on any of the wards we visited.

All hospitals were smoke free and this applied to staff as well as patients. Staff ensured that patients had access to a variety of nicotine replacement therapies and they supported patients with the use of specialist nurses, to work on reducing dependence on nicotine during hospital admissions.

Use of restrictive interventions

The below table focuses on the last 12 months' worth of data: 1 April 2018 to 31 January 2019.

Ward name	**Seclusions**	**Restraints**	**Patients restrained**	**Of restraints, incidents of prone restraint**	**Of restraints, incidences of rapid tranquilisation**
Croydon PICU, Bethlem Royal Hospital	35	81	55	26 (32%)	20 (25%)
Eden Ward (PICU), Oak House, Lambeth Hospital	19	36	42	9 (25%)	17 (47%)
Eileen Skellern 1, Maudsley Hospital	49	149	78	58 (39%)	71 (48%)
Johnson PICU Ward, Ladywell Unit	36	71	54	24 (34%)	34 (48%)

Staff had a good understanding of the need to minimising restrictive interventions including restraint and seclusion and the use of rapid tranquillisation when it was not planned. We found that while there were some increases in the use of these interventions, for example, on ES1 there were 149 incidents of restraint between 1 April 2018 and 31 January 2019 whereas there had been 76 incidents of restraint between 1 February 2017 and 31 January 2018. Staff were able to talk about the differences in patient need but there was a marked increase in these numbers. However, on Eden Ward, there had been a significant decrease in the numbers of restraint in these time periods, with 36 incidents between 1 April 2018 and 31 January 2019 which was down from 55 in the period between 1 February 2017 and 31 January 2019.

Across the service, teams attended local meetings based on the separate hospital sites where there was a specific focus on the work being down to reduce incidents of restrictive interventions. All staff we spoke with across the four hospitals we visited were able to tell us about the work being done to reduce restrictive interventions.

We checked incidents of seclusion on the wards we visited. We found that all records of seclusion had been completed with the relevant observations and reviews being carried out in a timely manner.

We checked examples of incidents of restraint in all the wards we visited. We saw that there had been improvements in the recording of restraint. Each incident was reported as an incident of restraint with the position and length of time of the restraint. Details of each member of staff involved in the restraint was also noted. There were some records where it was not always clear in the progress notes that restraint had taken place but where the information was not in the progress notes, it was available elsewhere in detail. This meant that the trust had accurate information about the use and levels of restraint and seclusion. Staff and patients told us that patients had debriefs after the use of restraint. However, it was not always clearly documented in care records that these debriefs had taken place.

Staff on the ward were aware of the trust policies and National Institute for Health and Care Excellence (NICE) guidance on the physical monitoring of patients after the use of rapid tranquillisation. At our previous inspection in August 2018, we found that there were gaps in the records of this monitoring. We found this was improved in this inspection. Staff had a clear understanding of the need to monitor physical health after the administration of rapid tranquillisation and the services had robust audits in place to ensure that this was carried out. This meant that patients received safe care.

Safeguarding

Staff had training on how to protect patients from abuse and understood when to raise concerns around safeguarding both children and adults. However, we saw examples on ES1 and Eden Ward where, while patients had been kept immediately safe, it was not clear that the trust safeguarding policies had been carried out as decisions had been made locally not to raise safeguarding concerns because action had been taken to safeguard the patients involved. This meant that there was a risk that safeguarding was not being reported because action had been taken. After the inspection, we were told that additional training had been put into place in Lambeth to address some of the concerns raised.

Staff access to essential information

Staff had access to clinical information about patients and it was easy for them to maintain high quality clinical records. We saw that some teams had moved to an electronic observation tool which records physical health observations on a tablet and then carried the information over to the main patient records. Where there had been problems in accessing data through this relatively new system, the wards had reverted to a paper-based system. This meant that information was available in a timely manner and there were systems in place to ensure that the processes were still able to function if there were a failure in the electronic systems.

Medicines management

The service prescribed, administered, recorded and stored medicines well. Staff had a good understanding of the relevant best practice guidance regarding the prescribing and administration

of medication. All nurses who were responsible for administering medicines had specific training and competencies they had to complete.

Each ward had access to support from a pharmacist. On ES1, the hospital pharmacist facilitated a group on the ward with the occupational therapist to help to answer any questions patients had about their medicines. This meant that patients were provided with information about medicines.

Staff monitored fridge and ambient temperatures to ensure medicines were safe to administer. We saw that these records had been completed and staff were aware of escalation routes if they had concerns about the temperature of the storage of medicines.

We checked prescription charts on the wards we visited and saw that they were completed and patients received their medicines as prescribed. There were pharmacy audits in place from the local pharmacy teams to ensure medicines were administered safely and recording was comprehensive.

Track record on safety

The following incidents were reported in the PICUs between 1 April 2018 to 31 January 2019.

	Number of incidents reported							
Type of incident reported (SIRI)	**Apparent/actual/suspected self-inflicted harm**	**Disruptive/aggressive/violent behaviour**	**Pending review**	**Slips/trips/falls**	**Abuse/alleged abuse of adult patient by third party**	**Unauthorised absence**	**Abuse/alleged abuse of adult patient by staff**	**Total**
Croydon PICU, Bethlem Royal Hospital	1							**1**
Eden Ward (PICU), Oak House, Lambeth Hospital		1			1			**2**
Johnson PICU Ward, Ladywell Unit						1		**1**

Reporting incidents and learning from when things go wrong

Staff across the services had a good understanding of incident reporting processes and knew how to report incidents. Staff gave us examples of learning from incidents within their wards and their local hospital sites.

Each ward had regular team meetings and local governance meetings where learning from incidents was discussed and this included incidents from other wards where there was relevant learning.

All staff had access to bulletins which were made available to all staff in the trust which highlighted key learning from serious incidents. Every borough produced a quarterly report specifically about incidents and learning locally.

There were some examples of incidents where we found that learning was not embedded, for example, during the inspection, we were told about similar incidents on Croydon PICU and at

Eden Ward which had both taken place in January 2019. It was possible there may have been cross learning between these incidents but there was no evidence that there had been any discussion between the ward managers about potential learning from each other. We also received information about an incident on Eden Ward in January 2019 and checked the lessons learned on the incident recording system. We saw that this incident had led to lessons regarding relational security on the ward. However, in the fact finding report after the incident, concerns were raised about the necessary renovation in the seclusion room. However, this was not added to the local risk register until late March. This meant that there was a risk that issues identified to learn, even when they could not be immediately actioned, may not have had a clear route to be escalated on the risk registers.

Staff told us that they had access to debriefing after incidents. There was a centralised critical incident staff support service (CISS) which provided additional assistance to staff following incidents including reflective sessions. We spoke with a team who had received support from this team following an incident on the ward and they told us that this input was helpful.

Is the service effective?

Assessment of needs and planning of care

We reviewed 59 care records across all four hospital sites. The quality of assessments and care planned was generally good.

Staff completed a comprehensive mental health assessment of each patient in a timely manner after their admission. Staff recorded all assessments in patients' progress notes on the electronic patient record. Assessments followed a standard format covering the circumstances leading to admission, mental health history, social circumstances, current presentation and current medication.

Staff assessed patients' physical health needs in a timely manner after admission. Doctors usually completed these assessments at the same time as the initial mental health assessment. Physical assessments included a physical examination and checks of the patient's blood pressure, heart rate, respiratory rate and oxygen saturation. Doctors also carried out blood tests and electrocardiogram tests. On Wharton Ward, we saw a good example, where staff discussed patients' female reproductive health on admission.

At the last inspection in July 2018, the quality of patient care plans varied and, in a few cases, did not always reflect patients' needs. For example, needs related to patients' physical health or autism. At this inspection, improvements had been made. Staff developed care plans that met the needs of most patients identified during admission. The multidisciplinary team agreed plans for care and treatment with each patient at regular ward rounds. Most patients had care plans relating to their mental health, physical health, and specific risks such as neglect, violence or aggression. However, on Powell Ward, one patient, who was admitted in December 2018, did not have a care plan in place. On Virginia Woolf Ward, one patient did not have a care plan to address their clozapine treatment. However, we could see that staff were managing the patient's clozapine treatment appropriately through the patient's progress notes.

Care plans were personalised, holistic and recovery orientated. Most care plans related to patients' mental health and reflected the standard treatment offered on the wards such as compliance with medicines for the treatment of mental illness, having regular discussions with nursing staff and engaging in ward activities. Care plans were recovery-oriented and contained patients' wishes and goals. On Jim Birley Unit, we saw a good example of a personalised care plan that considered what preferred pro-noun a patient would like to be referred to if they identified as LGBT+. On Gresham 2, care plans were completed in collaboration with patients and were 'jargon free' to ensure they were patient-friendly. On Virginia Woolf, staff created a specific care plan for a patient's trip to Birmingham, which included communication methods for the patient to use if they felt anxious, for example, flash cards.

Staff updated care plans regularly, this usually happened during the patients' weekly multidisciplinary meeting.

Best practice in treatment and care

Staff provided a range of care and treatment intervention suitable for the patient group. Patient records demonstrated good practice in relation to prescribing medicines and using outcome measures.

Guidance by the National Institute for Health and Care Excellence (NICE) on the treatment for psychosis or schizophrenia states that hospitals should provide antipsychotic medication in

conjunction with psychological interventions. We found that all patients with psychosis or schizophrenia were receiving antipsychotic medication. There was limited access to nationally recommended psychological therapies. There was one clinical psychologist based at each hospital providing input for a few hours a week to each ward. The clinical psychologists provided weekly group sessions for patients, which included hearing voices. Staff teams told us they could make referrals for individual psychological interventions as recommended by NICE. However, on LEO unit, there was greater psychology input, and patients had access to psychology input three days a week. LEO unit provided a specialist service for people experiencing their first episode of psychosis.

Occupational therapists facilitated groups on the wards, for example, smoothie making and cooking and assessed patients' daily living skills and provided individual support to patients..

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. For example, on LEO Unit, staff supported a patient to the local hospital for day surgery. On Rosa Parks Ward, staff referred a patient with diabetes to dietetic services. On Rosa Parks Ward staff pro-actively liaised with cardiology services to try and address a patient's tachycardia, despite the patient often refusing to engage. On Luther King Ward, staff held a weekly physical health clinic, to ensure regular monitoring of patients' physical health on the ward.

At the last inspection in July 2018, staff did not always carry out physical observations of patients with specific physical health needs. For example, staff had not completed blood glucose monitoring consistently on one ward. On Aubrey Lewis 2, staff were not consistently completing food and fluid charts for one patient. Staff had not taken action to address a patient's recorded low fluid intake. At this inspection, progress had been made, but there was still room for improvement. Staff recorded physical observations of each patient using National Early Warning Score (NEWs) and escalated scores that indicated physical health deterioration. Staff mostly took a pro-active approach in supporting patients with their physical health needs, including taking regular blood tests when required and monitoring blood glucose for patients with diabetes. However, on Powell Ward and Virginia Woolf, we found gaps in the recording of blood glucose monitoring for three patients with diabetes.

Staff assessed patients' needs for food and drink and for specialist nutrition and hydration on admission. However, on Gresham 1, two fluid charts had not been completed for a patient, therefore it was not clear if the patient had consumed adequate fluids over two days. On Virginia Woolf Ward, the body mass index of two patients was classed as obese, and there were no physical interventions in place to support them with this identified need.

Staff supported patients to live healthier lives. For example, staff supported patients with smoking cessation. Smoking was not permitted at any of the hospitals and staff provided nicotine replacement therapy. At the Maudsley Hospital, the wards had achieved 100% for their smoking advice audit, in which they confirmed patients' smoking status at admission and gave smoking cessation advice. Most patients could access a gym and 'healthy living' groups facilitated by the occupational therapist. During the inspection, at the Bethlem Hospital, a football player from the local football team came to open the new on-site gym. Jim Birley Unit offered yoga to patients and ran a weekly health and well-being clinic to improve patients' physical health needs.

At the Ladywell Hospital, there was a dual diagnosis nurse who helped develop dual diagnosis care plans for patients with co-morbid substance misuse needs.

Staff used recognised rating scales to assess and record severity and outcomes. Staff completed an assessment of each patient's mental health shortly after admission using the Health of the

Nation Outcome Scales (HoNOS). Further HoNOS assessments were carried out during the admission to measure the patient's progress. Occupational therapists used the model of human occupation screening tool to measure the impact of occupational therapy input.

Some wards had been trialling monitoring patients' physical observations electronically, with the aim of automatically updating patients' records with the outcome of the observations. However, staff told us that this had not been working as planned and they had gone back to recording patients' physical observations on paper.

Staff participated in clinical audits of the wards to monitor care provided. For example, staff completed audits on care plans, risk management plans, infection control, prescription charts, clinic rooms and equipment. Since our last inspection, the matron had been completing regular audits of rapid tranquilisation incidents to ensure the necessary physical health observations had been carried out.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients on the ward. As well as doctors, nursing team and occupational therapists, pharmacists regularly visited the ward and were involved in multidisciplinary decisions. The ward could refer patients to dieticians and speech and language therapists if necessary. However, the provision of clinical psychologists on most acute wards was limited.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff were appropriately qualified for their posts and senior staff were experienced within their roles. Staff completed competencies to assess their ability to use medical devices safely and effectively, and the administration of medicines.

Managers provided new staff with appropriate induction. New staff received a comprehensive induction that orientated them to the ward. Agency and bank staff had an induction checklist they had to complete when starting on the wards.

The percentage of staff that had had an appraisal as of 29 December 2018 was 91%. The wards with the lowest appraisal rate at 29 December 2019 were LEO Unit with an appraisal rate of 76%.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 29 December 2018)
John Dickson Ward	28	27	96%
Croydon PICU	25	24	96%
Gresham 2	24	23	96%
ES1 Ward	24	23	96%
Lewisham Triage	23	22	96%
Jim Birley Unit	22	21	95%
Nelson Ward	21	20	95%
AL3 Ward	20	19	95%
Ruskin Unit	19	18	95%
Johnson Unit	26	24	92%
Gresham 1	25	23	92%
Luther King Ward	24	22	92%

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 29 December 2018)
Wharton Ward	21	19	90%
Tyson West 1	20	18	90%
Clare Ward	20	18	90%
Powell Ward	25	22	88%
Rosa Parks	22	19	86%
Eden ICU	22	19	86%
ES2 Ward	23	19	83%
Fitz Mary 1	17	14	82%
LEO Unit (Early Intervention)	29	22	76%
Core service total	**480**	**436**	**91%**

At the last inspection in July 2018, staff supervision continued to be low with 52% of staff receiving supervision in accordance with the trust's policy in the year from March 2017 to February 2018. Although this improved between April to June 2018 to 75%, nearly one quarter of the acute wards had completed less than 65% of planned staff supervision in that period. This made it difficult for managers to provide support to staff and address their developmental needs. At this inspection, supervision had improved on most wards, but remained low on LEO Unit, Rosa Parks Ward and John Dickson. For example, on LEO Ward, during February 2019, 45% of staff received supervision. This had increased to 86% in March 2019. Staff said supervision had not been carried out due to changes in ward managers. On Rosa Parks Ward, supervision was low. In February and March 2019, 65% of staff had received supervision. Staff reported that this was due to staffing shortages.

Staff across the service told us that they had access to fortnightly reflective practice groups on the wards which were externally facilitated, and they found this useful.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. On Aubrey Lewis 2, staff had access to a one-hour weekly training development session, which was based on staff training needs or interests. At the Bethlem Hospital, the clinical psychologist provided dialectic behavioural training (DBT) to nursing staff, so in turn the nursing staff could provide DBT to patients.

At the last inspection in July 2018, we found that although staff had access to training in caring for patients with learning disabilities, this training did not specifically include autism. There were a number of patients with autism admitted to the wards, and staff said they did not have access to autism training. At this inspection, most staff had not received autism training. Since our inspection, the trust provided a rolling autism training programme for all acute wards.

Managers dealt with poor staff performance promptly and effectively. Managers reported that they received appropriate support from their line managers and the trust's human resources department.

Managers recruited volunteers when required and trained and supported them for the roles they undertook. On Powell Ward, volunteers were trained to facilitate patient activities during the week and weekends, such as table tennis.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary team (MDT) meetings. For example, we attended an MDT meeting on LEO Unit, and saw that patients care and treatment were comprehensively discussed, including the patients' medicines, leave and risk.

Staff shared information about patients at effective handover meetings within the team. Staff worked collaboratively to deliver patient care and there was good communication and handovers between disciplines. Staff shared information using a standard format covering each patient's presentation, risk rating, involvement in incidents, involvement in activities, sleep, compliance with medicines and food intake. We observed handovers that were comprehensive and included all the details needed for oncoming staff to meet the needs of patients.

The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation. For example, staff on Rosa Parks Ward described good working relationships with the home treatment team as they shared the same speciality doctor who was on the ward four times a week. Wards invited care co-ordinators to inpatient meetings, but they did not always attend.

The ward teams had effective working relationships with teams outside the organisation. Ward staff regularly spoke with housing and third sector organisations to support patient accommodation issues. Staff on Rosa Parks Ward had worked closely with a local charity in Lambeth that provided activities to assist patients in regaining their confidence and self-esteem. Staff said this had been successful in assisting patients to live well in the community.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2018, 84% of the workforce in this service had received training in the Mental Health Act (MHA). Training was mandatory for all inpatient and staff and renewed every three years.

Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who the MHA administrators were and how to contact them.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local MHA policies and procedures and to the Code of Practice through the trust intranet.

Patients had easy access to information about independent mental health advocacy (IMHA) services. An IMHA visited the wards at all the sites regularly. Staff explained to patients their rights under the MHA, in a way that they could understand, repeated it as required and recorded that they had done so.

Staff usually ensure that patients were able to take section 17 leave (permission for patients to leave hospital) when this had been granted. However, this was sometimes delayed or postponed when they were staff shortages on the wards. Patients' section 17 leave was discussed at regular multidisciplinary meetings.

Staff requested an opinion from a second opinion appointed doctor (SOAD), but this was not always done in a timely manner. On Gresham 1 and Gresham 2, we found a lack of timely requests for a SOAD when a patients' consent to treatment form had expired. There was evidence that a SOAD had not being requested until the three-month threshold was reached. Best practice would be to request a SOAD in advance where it is likely that someone would need a consent to

treatment form in the absence of consent or mental capacity. This meant that section 62 (urgent treatment) forms were used to cover the gap that was created by leaving a SOAD request at expiration of the consent to treatment forms.

On Tyson West 1 and Gresham 1, we found two patients receiving treatment for physical health conditions were not covered by their consent to treatment forms. It was not clear from the records what legal authority was relied upon to permit this treatment.

Staff stored copies of patients' detention papers and associated records correctly so that they were available to all staff that needed access to them. Original copies of statutory documents were stored in the MHA office. These documents were uploaded to the electronic patient record so that all staff had access to them.

The wards displayed notices to tell informal patients that they could leave the ward freely.

Staff conducted regular audits to ensure that the MHA was being applied correctly. MHA administrators completed monthly audits of the administration of the MHA.

Good practice in applying the Mental Capacity Act

As of 31 December 2018, 83% of the workforce in this core service had received training in the Mental Capacity Act (MCA). This training was mandatory for all inpatient staff and renewed every three years.

Most staff had a good understanding of the MCA and the five statutory principles. The staff we spoke with demonstrated a working knowledge of the MCA. Staff discussed capacity to consent in regular multidisciplinary meetings.

The trust had submitted 12 deprivation of liberty safeguards (DoLS) to the local authorities between 1 January 2018 and 31 December 2018. At the time of inspection, one of these had been approved.

Staff knew where to get advice from within the provider organisation regarding the MCA, including DoLS. Staff said they could seek advice from the MHA office or from social workers within the local authority. The provider had a policy on the MCA, including DoLS. Staff were aware of the policy and had access to it.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make the decision. Staff carried out best interest meetings when patients did not have the capacity to make a specific decision. For example, on Rosa Parks Ward, staff attended a best interest meeting for a patient who lacked capacity but needed support with identifying appropriate accommodation in the community.

However, on John Dickson ward, the trust had not sought a patient's consent to ECT treatment following the responsible clinician's assessment that the patient had capacity to consent, or otherwise.

For patients who might have impaired mental capacity, staff assess and recorded capacity to consent appropriately. They did this on a decision-specific basis. Doctors completed assessments of capacity to consent to admission and treatment for all patients. They corded their decision on the electronic patient record.

The service had arrangements to monitor adherence to the MCA. Staff audited the application of the MCA and took action on any learning that resulted from it.

Psychiatric Intensive Care Units

Assessment of needs and planning of care

Staff assessed the physical and mental health care of all patients on admission. They developed individual care plans and updated them when needed. We checked 15 care records including care plans across the four wards we visited.

Care plans were holistic and incorporated patients' physical and mental health care needs as well as social and psychological needs. Care plans indicated why the admission to the intensive care ward was needed and the progress towards moving on to another service. Some care plans did not clearly evidence discharge planning as some staff told us that was a focus when patients were transferred to acute wards. Patients' voices were clear in the care plans and staff ensured that preferences were taken into account and documented clearly.

Staff assessed patients' physical health on admission. These records were available on the electronic database. Staff ensured that care plans reflected specific physical health care needs where this was relevant. Staff were able to access specialist advice from a physical health care lead on each of the inpatient sites.

Staff monitored physical health of patients regularly according to individual need and risk. We checked these records had been completed. They were audited comprehensively on each ward to ensure they were taking place. Staff used the national early warning scores (NEWs) which identified any areas of potential concern which may need to be escalated for medical attention. Staff had a good understanding of the escalation routes when there were potential concerns about physical health.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Interventions were recommended by and delivered in line with guidance from the National Institute of Health and Care Excellence (NICE). There were processes in place in the trust to ensure that practitioners were updated with best practice.

Input from clinical psychologists varied across the service. For example, on Eden Ward, staff told us that there was access to a clinical psychologist to whom patients could be referred for individual work. Some, for example, on ES1 told us that they knew how to contact a clinical psychologist when necessary. Clinical psychology was not generally a feature of multidisciplinary team meetings which meant that there may be input regarding formulation and planning which was not accessed regularly, however, staff told us that if they had specific queries about an issue, they could access support from the psychology teams.

The service prioritised health promotion for patients on the ward. For example, there were proactive smoking cessation specialists within the trust who provided support and advice for patients who had been smokers and staff could request bespoke advice from nurses trained in nicotine replacement treatments. Staff also had access to support from specialist dual diagnosis workers.

Allied health professionals including occupational therapists used bespoke outcome measures when working with patients in innovative ways. For example, on ES1, the ward occupational therapist was looking at ways to relate the use of the sensory room on the ward to the reduction in the levels of restrictive practice.

There were regular clinical audits which took place on the wards we visited including audits of care plans and risk assessments, physical health checks and the use of the Mental Health Act. The outcomes of these audits were discussed in clinical governance meetings on the ward and across the service so that managers within the organisation could understand the quality of care delivery on the wards.

Skilled staff to deliver care

Staff had access to annual appraisals. At of 31 December 2018, an average of 93% of staff working on the PICUs had appraisals.

In our last inspection in August 2018, we saw that most teams were receiving regular clinical supervision, however on Eden Ward this was the lowest at 76%. Most staff we spoke with told us that they had access to supervision regularly. However, on Eden Ward, staff told us that there were times when they had not had access to regular supervision, due to shortages in permanent staff on the ward. We checked the data regarding supervision on the ward and saw that between September 2018 and February 2019, supervision rates on the ward were an average of 80%. However, this had dropped to 42% in November 2018. This meant that due to shortages in band 6 nurses who would usually be responsible for providing some supervision, there were some staff who were not able to access regular clinical supervision. Staff across the service told us that they had access to fortnightly reflective practice groups on the wards which were externally facilitated, and they found this useful.

All staff had comprehensive trust and local inductions to the wards. This included temporary staff. This meant that staff had information necessary to carry out their roles when they arrived on the wards. Nursing staff had access to specialist training around the management of aggression and violent behaviours including de-escalation techniques.

Managers within the service had systems in place to ensure that staff competence in specific areas such as medicines management was evaluated to ensure that staff could carry out core expected tasks on the ward.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. Ward teams included medical, nursing and occupational therapy input. Staff had access to support from clinical psychologists if requested. Pharmacists were available to provide advice on wards.

We observed some ward rounds and management rounds and saw that staff worked effectively in a multidisciplinary setting to share relevant information and ensure that patient care was prioritised. Information about key risks relating to patients' physical and mental health was shared within the team to ensure that all staff had the information necessary to work productively towards the recovery of patients on the ward.

We observed handovers on three of the wards we visited. We saw that key issues of risk were addressed and considered. On Johnson ward, staff were trialling a new form of handover where information was collated on the patients' electronic record. This followed from the trial of this handover on one of the other wards at the Ladywell Unit in Lewisham. This displayed how services used ideas from across the teams to work on improving practice and clinical safety on the ward so that information was shared in a clearer way between shifts.

Care and treatment records showed that staff liaised with external providers, agencies and trusts as necessary for the benefit of patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff in the service had a good understanding of the Mental Health Act (MHA). They were aware of their responsibilities under the MHA and were aware of where to seek advice if they required further support and assistance.

Staff on the wards had received training on the MHA.

On Croydon PICU we saw there was one example of a late request for a second opinion appointed doctor (SOAD) and on Eden ward, we saw some records which reflected a patient who had been detained under S3 of the MHA in the hour before their S2 admission expired. This indicated that staff needed a greater awareness of the time-limited issues around MHA.

Patients on the wards we visited had access to advocates and there was information available on the ward with relevant contact details.

Good practice in applying the Mental Capacity Act

Staff received training about the Mental Capacity Act (MCA) as part of their mandatory training programme.

Some doctors in the wards we visited, told us that they found the electronic template to record assessments of capacity to consent and capacity to treatment unhelpful to use. We checked recording for assessments of capacity on all the wards we visited. We found that there was variable practice, however, most of the assessments we checked were perfunctory and did not reflect a conversation which may have taken place with the patient where there was a question around their capacity. For example, on Eden Ward we saw two assessments of capacity which had been completed on consecutive days relating to the same patient. While it is possible that he may have had capacity to consent to treatment one day and not have capacity to consent to treatment on a subsequent day, there was no evidence in the content of the respective assessments that a conversation had taken place to reflect this fluctuating capacity. We found similar examples of very minimal narrative around discussions relating to capacity throughout the service. However, staff, including the doctors who had completed these assessments of capacity, had a good understanding of the provisions of the MCA and its use on a psychiatric intensive care ward, but the records did not consistently reflect this.

Is the service caring?

Acute Wards

Kindness, privacy, dignity, respect, compassion and support

We spoke with 66 patients and five carers across the acute wards during our inspection. Most patient and carer feedback were positive about the quality of care they received. Most patients told us they felt safe on the wards, that staff treated them with dignity and respect, and helped them with their recovery. For example, on Tyson West 1, patients said staff went out of their way to help them. Despite the staffing issues on some wards, patients on LEO Unit and Rosa Parks Ward, told us they felt safe on the ward, that staff were respectful, had access to activities, and felt involved in their care and treatment.

We observed many staff and patient/carer interactions during our inspection. Staff demonstrated a good understanding of patients' and carers' needs and interacted with them in a respectful and responsive way. For example, on Luther King Ward, it was clear that staff really understood

patients' needs and displayed positive therapeutic relationships with them. On LEO Unit, staff interacted with a carer in a caring and compassionate manner. On Tyson West 1, we observed two patients' ward rounds, where staff provided patients with help, emotional support and advice at the time they needed it.

At the last inspection in July 2018, while most staff cared for patients with kindness and compassion, feedback from patients on Ruskin/AL2 Ward said that some staff did not seem to care about them, were disrespectful towards them or too busy to help them promptly. At this inspection, this was no longer an issue. On Ruskin/AL2, patients were very complimentary about how they were treated by staff.

Staff support patients to understand and manage their care, treatment or condition. Staff met with patients regularly on an individual basis each day, and through weekly multidisciplinary ward rounds to discuss their care and treatment with them. Most patients we spoke to said they felt involved in their care and treatment. For example, on LEO Unit, patients told us they discussed their medicines and discharge in ward rounds and reviewed their care plans and risk assessment regularly with their named nurse. On Luther King Ward, patients had access to a benefits worker to support them with filling out paperwork relating to their benefits. On Eileen Skellern 2, staff had developed a 'complementary card' for formal and informal patients to carry while on leave. This card contained contact details for the ward and other helplines. The card was developed in response to incidents when patients forgot or misplaced ward contact details and could not make contact with staff during times of need.

Staff directed patients to other services when appropriate and, if required, supported them to access services. For example, on Rosa Parks Ward, staff supported patients to access a local charity that supported patients to regain confidence and self-esteem.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. For example, on Jim Birley Unit, a female nurse had been trained to perform electrocardiograms, in case a female patient's cultural needs required this. On Wharton Ward, we saw an example where a female patient had a female staff member present during their medical examination with a male doctor, demonstrating sensitivity to personal needs.

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. All staff said they would approach the ward manager if they had any concerns.

At the last inspection in July 2018, we found that confidential information was visible to people standing outside the nurses' office. At this inspection, this was no longer an issue. Computers in the nursing office had privacy screens on them, and whiteboard containing patient information was able to fold close when not in use.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing score for Lambeth Hospital was 88%. The score for the Maudsley Hospital was 87%. The score for the Bethlem Hospital was 92%, and the score for the Ladywell Unit was 85%. This compared to an overall average score of 89% for the trust and 99% for mental health and learning disability services in England.

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Most patients told us that they were oriented to the ward. For example, on LEO Unit, patients said staff

showed them around the ward and introduced them to staff when they arrived. At the Ladywell Unit, staff provided patients with an information booklet when they were admitted to the ward. However, four patients at the Ladywell Hospital told us staff had not oriented them to the ward.

Staff involved patients in care planning and risk assessment. This was demonstrated through inspection of patient care records and feedback from patient interviews.

Staff communicated with patients so that they understood their care and treatment. Staff spoke to patients clearly using language that was easy to understand. We saw that care plans were adapted when required to ensure patients could easily understand them. On Rosa Parks Ward, the pharmacist provided 'discharge' medicines support to ensure patients were confident at taking their medicines in the community.

Staff involved patients when appropriate in decisions about the service. For example, in the recruitment of staff.

Staff enabled patients to give feedback on the service they received. For example, each ward held weekly community meetings. During these meetings patients were encouraged to speak and be involved in the meeting. Staff kept written minutes of meetings. We reviewed minutes on Wharton Ward, Gresham 2 and Fitzmary 1, where patients raised issues about food, activities, ward cleanliness and staffing. Patients were also able to complete a brief survey stating whether they would recommend the service to a friend of a family member. In addition, at the Bethlem Hospital, a local advocacy service called 'hear us' consisting of peer support workers attended the wards each week and collected feedback from patients, who when fed back to ward managers.

Staff ensured that patients could access advocacy. An advocate visited each ward once a week. Staff displayed information on how patients could contact an advocate on all wards.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. For example, on Clare Ward, the consultant psychiatrist offered telephone calls with families and carers to involve them and enable them to offer any suggestions for improvement. Where appropriate, staff invited families and carers to attend patient multidisciplinary team meetings. Carers we spoke with said they felt involved in their relative's care and treatment and felt supported by staff.

Staff enabled families and carers to feedback on the service they received. For example, via surveys saying whether they would recommend the service to people they know. At the Bethlem Hospital, the wards facilitated monthly carer forums for carers to attend and give feedback. Staff also used this opportunity to support carers by signposting them to appropriate services, if required.

Staff made referrals to the community mental health teams if they identified that a carer required a carers assessment. On Clare Ward, staff completed a carers' audit. This included checking that staff contacted the patient's carer/family to assess of they required additional support, such as a carers assessment.

Psychiatric Intensive Care Units

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity and supported their individual needs. We spoke with nine patients and three carers. Most patients we spoke with were very positive about the quality of care they received and told us that staff were

caring and respectful towards them. In our previous inspection in August 2018, we had mixed feedback from patients with some describing care which was not respectful. This had improved and was no longer an issue at this inspection.

We observed interactions between patients and staff while on the ward and attended one patient group on Eden Ward. We saw that staff displayed care and skill in their interactions with patients and this reflected their attentiveness and knowledge of the patient group. Staff had comfortable, unforced interactions and were able to talk to us about individual patient need and preference in a way that indicated a good understanding of the needs, wishes and preferences of patients on the ward.

Involvement in care

Involvement of patients

Each ward had a daily planning meeting which involved patients and the ward occupational therapist discussing the plans for the day. Wards had weekly community meetings where information and feedback could be shared. We checked minutes from these meetings on the wards we visited and saw that patients had the opportunity to provide feedback and that staff followed up on issues raised.

Staff gathered feedback information through the patient experience data intelligence centre (PEDIC) which collected this feedback either through a tablet computer or on paper. This feedback was shared with the ward monthly and could be tracked. It was discussed in local governance meetings, so it could be used to inform service improvement.

We saw some evidence of patient involvement in care planning with patient comments and feedback gathered. Patients told us that they had been given information about their care plans and plans for recovery by staff.

Wards had information which they gave to patients on their arrival which included brief information about timetables and expectations on the ward. This provided a brief orientation to the services.

Involvement of families and carers

We spoke with three family members. Generally, we received positive feedback about the services and the efforts made by staff on the wards to engage with carers.

On ES1, staff had developed a ward specific carers' strategy which included a weekly 'surgery' with the ward consultant and other staff to meet with family members or carers if they wished. The staff on the ward were considering changing the times of this to ensure they maximised accessibility.

Is the service responsive?

Acute Wards

Access and discharge

Bed management

At the last inspection in July 2018, the flow of patients into and out of the service was poor. Bed occupancy was above 100% on seven wards. At this inspection, the number of wards with a bed occupancy above 100% had increased. Managers said the demand on patients requiring an inpatient acute bed remained a significant issue. The trust provided information regarding average bed occupancy for wards in this core service between 1 February 2018 to 31 December 2018. All of the acute wards reported bed occupancy ranging above 85% throughout this period. 15 wards

had bed occupancy rates above 100% throughout the year. These were ES2, Nelson Ward, Fitzmary 1, Clare Ward, Rosa Parks Ward, Tyson West, AL3, Wharton Ward, Gresham 1 and 2, Jim Birley, John Dickson, Luther King Ward, LEO Unit and Powell Ward.

Ward name	Average bed occupancy (1 February 2018 – 31 December 2018)
Rosa Parks Ward Female	126%
ES2 Ward - Maudsley	118%
Nelson Ward - Landor Road	114%
Fitzmary 1	113%
Clare Ward Male	110%
Rosa Parks Ward Male	110%
Tyson West 1 Male	110%
AL3 Ward Maudsley	107%
Wharton Ward - Ladywell	107%
Gresham 2	106%
Jim Birley Unit - Maudsley	103%
John Dickson Ward	103%
Luther King Ward - Landor Road	103%
Gresham 1	102%
Leo Male	102%
Powell Ward - Ladywell	102%
Leo Female	100%
Virginia Woolf Ward	96%
Ruskin Unit	95%

Patients typically stayed on acute wards for around 40 days. However, the monthly length of stay on Gresham 2 was considerably higher at 89 days. However, since our last inspection in July 2018, some wards had seen a reduction in the average length of stay. For example, at the Ladywell Unit, the average length of stay had decreased to 30 days, and the average length of stay in Gresham 1 had reduced from 110 days to 67 days since our last inspection.

At the last inspection, the trust had placed 296 patients in out-of-area beds in the year from February 2017 to January 2018 because of a lack of available beds within the acute wards and PICU. At this inspection, there had been a slight increase in the number of out-of-area placements. The core service reported 300 out-of-area placements between 1 February 2018 and 31 December 2018. During this time, there were three placements that lasted less than one day. The placement that lasted longest amounted to 372 days. Two-hundred and ninety of the 300 out-of-area placements were because there were no beds available on the acute wards. Ten placements were because another hospital was considered to be better suited to meet the patients' needs. The trust was working to minimise out-of-area placements and bring patients back to the local area. In March 2019, the trust had 56 out-of-area placements, this included 11 beds for Corydon patients with another NHS trust in London.

At the inspection in July 2018, there was not always a bed available for patients returning from leave. This meant that four patients returning from leave or recalled to hospital and 27 patients returning from being absent without leave slept on sofas, in de-escalation rooms and in other areas of the wards until a bed could be found. There was not always a bed available for patients who needed a transfer to a psychiatric intensive care unit. This led to patients being secluded in unsuitable environments such as bedrooms, sometimes for many hours, whilst they were waiting to be transferred. At this inspection, there had been improvements, but there were still four

incidents where a bed was not available when patients returned from leave. For example, on Fitzmary 1, a patient returned from leave unexpectedly late at night, and slept on a sofa in an interview room. Staff found them a bed the next day. The trust had informed CQC each time this happened.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. For example, on Rosa Parks Ward (mixed-sex ward), a female patient was moved to Nelson Ward (female ward) due to displaying disinhibiting behaviour.

When patients were moved or discharged, this happened at an appropriate time of day. This usually happened during Monday to Friday between 9am and 5pm when the multidisciplinary team were present.

A bed was not always immediately available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and treatment. On Tyson West 1, staff were waiting for a PICU bed for a distressed patient and had to seclude them on the ward while they waited for a bed. The patient was taken out of seclusion the next day and transferred to a PICU. As the trust had one female PICU, managers told us that there was sometimes a delay for a transfer from acute to female PICU. For example, on Gresham 1, staff told us they had to wait three days for a PICU bed. Managers told us if there could not find a bed on a PICU, they had to source a private bed in independent hospitals.

Discharge and transfers of care

At the last inspection in July 2018, 20% of patient discharges from hospital were delayed. Staff were not always proactive in addressing barriers to patients being discharged. In some wards, there was very little discharge planning reflected in patients' care plans. At this inspection, there had been an improvement in the number of delayed discharges and staff were proactive in addressing barriers to patients being discharged.

Between 1 February 2018 and 31 December 2018, there were 1770 discharges within this core service. Of the 1770 discharges, 46 (3%) were delayed. Delayed discharges reported during this inspection was lower than the 357 (20%) reported at the last inspection. Managers had a good oversight of the number of delayed discharged for their wards. Managers identified accommodation in the community being the biggest barrier to patients' discharge.

Staff planned for patients' discharge, including good liaison with care co-ordinators. Staff invited care co-ordinators to ward rounds. On Rosa Parks Ward, they had a dedicated discharge co-ordinator who ensured patients' discharge was regularly reviewed. On Luther King Ward, staff used a detailed handover tool, which identified actions that individual staff were undertaking to facilitate discharge. This included contacting social services, care co-ordinators and other agencies. Actions were then reviewed at each meeting to ensure they had been completed.

Some of the wards had piloted the Red2Green project. Red2Green is an action orientated, purposeful conversation that takes place daily for each patient aiming to improve inpatient flow, by asking 'is today a red or green day?' A green day means that there is something actively happening that day to address any barriers to move the patient through the pathway they are in.

Since the last inspection in July 2018, the trust implemented multi-agency discharge events (MDAE) involving local partners and stakeholders. The events involved the review of all patients with a length of stay over 50 days, within one London borough, with a view to identifying and removing barriers to discharge. For example, in January 2019, a MADE event successfully

discharged 35 delayed discharges to appropriate step-down services. At Lambeth Hospital, staff held 'mini-MADE' events at the end of each weekly bed management meeting to further discuss delayed discharges.

Discharge was often delayed for non-clinical reasons. For example, on Luther King Ward, reasons for delays to discharge included patients waiting for placements in residential care, patients subject to the Court of Protection and patients with specific forensic risks.

Staff supported patients during referrals and transfers between services. For example, staff accompanied patients if they required treatment at local acute hospitals.

Facilities that promote comfort, dignity and privacy

Patients were provided with single bedrooms with shared bathroom and shower facilities. Most wards promoted privacy and dignity by having a vision panel on patients' bedroom door, which could be controlled by the patient and staff. However, on LEO Unit, not all the bedroom doors had the double controlled vision panels. Some of the bedroom doors had observation panels that were part frosted and part transparent, which meant patients did not have control to close them if they wished to. To mitigate this, staff had put curtains over the windows to promote privacy and dignity. However, some of these curtains were missing and not been replaced. This meant that patients and staff passing by could see into patients' bedrooms, which did not promote privacy and dignity.

Patients could personalise their bedrooms. For example, we saw that patients had brought in family photographs and posters of their choice to decorate their bedrooms.

Most patients, where appropriate, had a key to their bedrooms. Patients had somewhere secure to store their possessions. However, on LEO Unit, the safes in patients' bedrooms were broken and did not lock. Managers said that this had been reported to the trust's estates team but had not yet been fixed. Staff encouraged patients to store valuables such as mobiles in the nursing office, and important documentation in a trust safe on site.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. All wards had a dedicated clinic room, which included an examination couch, scales and equipment to conduct physical health examinations. Patients had access to a kitchen and a laundry on the ward to support activities of daily living. Patients had access to a range of art equipment, books and board games.

On LEO Unit, the ward was not well-maintained. Artwork in the female lounge had been damaged and not replaced. The female shower room drainage was poor. There were 15 dining room chairs that did not accommodate the 18 patients on the ward. Managers said that these issues had been reported to maintenance.

There were quiet areas on the ward and a room where patients could meet visitors. Patients had access to outside space. At the Maudsley Hospital, staff told us that when the weather was nice they would carry out activities such as yoga and mindfulness in the garden with patients. On Eileen Skellern 2, staff supported patients in growing their own fruit and vegetables, and these were used during cooking sessions with the occupational therapist.

Patients could make a phone call in private. Patients kept their mobile phones with them to contact friends and families. If patients did not have a mobile phone, they could use the ward's cordless mobile phone. On Gresham 1, the ward had introduced a charging tower in the communal living area, where patients could lock away their phone whilst it charged. This promoted independency for patients, rather than asking staff to do this for them.

We generally received positive feedback from patients about the food they received. Most patients said the food was good and that there was a varied selection. The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food scored lower than similar trusts. The trust overall score was 89%, and the England average for mental health and learning disabilities was 92%. At Lambeth Hospital they scored 88%, at the Maudsley Hospital they scored 84%, at The Bethlem Royal Hospital, they scored 92% and at the Ladywell Unit they scored 83%.

Patients could make hot drinks and snacks 24/7.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. For example, one patient told us they had been supported by staff to look for employment opportunities. Some patients attended courses at college.

Staff supported patients to maintain contact with their families and carers. Staff invited families and carers to patient multidisciplinary meetings where appropriate and encouraged patients to utilise leave with their loved ones.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. We saw examples where staff had signposted patients to appropriate local community groups to support them in making new and meaningful relationships. Occupational therapists escorted patients on leave in the community to build up their confidence with activities such as shopping and travel commuting.

Meeting the needs of all people who use the service

The trust made reasonable adjustments for disabled patients. For example, most wards had lifts for patients to use if they had limited mobility.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, how to complain and so on. Staff displayed this information on notice boards on each of the wards.

Staff said if there was an identified need they could access leaflets and documents in different languages via the trust intranet. For example, on Gresham 2, a patient had their rights under the mental health act explained to them via a leaflet in their chosen language. On Tyson West 1, a patient told us that staff gave them information in Italian, their first language.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Patients told us they had access to an interpreter as and when required.

Staff supported individuals who identified as lesbian, gay, bisexual or transgender (LGBT+). For example, some staff wore the trust's rainbow coloured lanyard attached to their staff ID to indicate that they were supportive of LGBT+ patients. On Gresham 2, anti-discrimination against protected characteristics such as sexuality was a regular agenda item on the community meeting minutes.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. This included halal and vegan options. Staff and patients told us any other requirements such as kosher and gluten free would be ordered in for the patient.

Staff ensured that patients had access to appropriate spiritual support. Wards displayed information about the chaplaincy service that patients could access. At the Maudsley Hospital, patients could access the chapel. Staff supported patients with their spirituality while on leave as well. For example, staff liaised with the local mosque to arrange for a Muslim patient to offer prayers while on leave.

Listening to and learning from concerns and complaints

The core service received 101 complaints between 1 January 2018 to 31 December 2018. Fifteen of these were upheld, 36 were partially upheld and 25 was not upheld. None were referred to the Ombudsman. Gresham 1 had the highest number of complaints (12), and Powell Ward had the lowest number of complaints (1).

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Unknown	No further action identified	Withdrawn
Gresham 1	12	1	6		5		
Rosa Parks	8	5			2	1	
Fitz Mary 1	7	1	3	1	2		
Jim Birley Unit	7		5	2			
Wharton Ward	7		4	1	1		1
ES2 Ward	6	1	1	2		1	1
Nelson Ward	6		1	4		1	
Ruskin Unit	6		3	2	1		
Gresham 2	5		1	3	1		
John Dickson Ward	5	2	3				
Tyson West 1	5			2	3		
Johnson Unit	4	1	1	1	1		
LEO Unit (Early Intervention)	4	1	1	1	1		
Virginia Woolf Ward	4	1	1	2			
Eden ICU	3		1	1			1
ES1 Ward	3		1	2			
Luther King Ward	3	1	1		1		
AL3 Ward	2	1	1				
Clare Ward	2		1	1			
Croydon PICU	1				1		
Powell Ward	1		1				
Core Service Total	**101**	**15**	**36**	**25**	**19**	**3**	**3**

Patients knew how to complain or raise concerns. On each ward, staff displayed information on how patients could make a complaint. Patients said they would approach the ward manager or complete a form if they wanted to complain. On Powell Ward and Virginia Woolf Ward, ward managers held a weekly surgery where patients and their families could meet to discuss concerns they had.

When patients complained or raised concerns they generally received feedback from the trust. For example, on Virginia Woolf, a patient told us they were impressed by how quickly the trust had

dealt with their formal complaint. A patient at the Maudsley Hospital, told us they had received positive feedback from staff following concerns they had raised.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Managers kept complaint information on the trust's secured electronic complaints database.

Staff knew how to handle complaints appropriately. When ward managers received an informal complaint from patients, they attempted to resolve the matter straight away. Most managers sent an acknowledgment and replied to the complainant within timescales set out in the trust's policy. However, on Rosa Parks Ward, we found four patients and carers did not receive holding letters or final complaint responses to their concerns raised when these were required. For example, a carer had made a complaint in February 2019, but had not received correspondence from the trust to update them on the status of their complaint.

Staff received feedback on the outcomes of investigations of complaints and acted on the findings. Staff included discussion about the outcomes of investigations into complaints as a standing item on the agenda for clinical governance meetings.

Psychiatric Intensive Care Units

Access and discharge

The trust provided information regarding average bed occupancies in this service between 1 February 2018 to 31 December 2018. The national average recommended occupancy level is 85%. Only one of the PICUs managed to achieve this.

Ward name	Average bed occupancy (1 February 2018 – 31 December 2018)
Eden ICU - Landor Road	99%
Croydon PICU	95%
Johnson Unit - Ladywell	94%
ES1 Ward - Maudsley	84%

The trust provided information for average length of stay for the period 1 February 2018 to 31 December 2018.

Ward name	Average length of stay range (1 February 2018 – 31 December 2018)	
Croydon PICU	25	54
Eden ICU - Landor Road	22	53
ES1 Ward - Maudsley	16	41
Johnson Unit - Ladywell	13	40

At the time of our inspection, the wards we visited were full apart from ES1 where there were 8 patients admitted on a 10-bed ward. The ward managers linked with the local services to proactively manage patient flow across the crisis and inpatient services including the provision of intensive care beds. Bed management was centralised in the Acute Referral Centre (ARC).

Since the last inspection, the trust had strengthened local governance and worked on improving patient flow through acute wards including the psychiatric intensive care wards. As part of this process, meetings had been developed which brought together people within the pathways locally within the boroughs, so that, for example, the ward managers, community team managers and local authority including housing teams were able to raise concerns and highlight need regarding proactively managing patients where there may be barriers to discharge.

PICUs had clear admission criteria which ensured that expectations were understood when patients were referred to the service. Admission criteria and exclusion criteria were explained in the trust operational policies for the PICUs.

However, on ES1, which, as the only female PICU in the trust, liaised with the four boroughs, staff told us that there had been particular challenges when trying to discharge patients to acute beds within the trust. We were told by staff that they raised incidents when this happened and they encouraged patients to complain when this happened. Following our inspection, we requested information from the trust about the number of these incidents that had been raised over the previous six months between 1 October 2018 and 31 March 2019. Four incidents had been reported in this period, however one of these incidents referred to three different patients whose transfer to an acute ward were delayed, which meant that at least six patients experienced care at a level of security higher than they needed. These incidents related to patients expressing frustration at their delay in being transferred to an acute ward and in one incident, related to a concern about potential safeguarding risk due to level of vulnerability of the patient on the ward. At the time of our inspection, we were told that out of the eight patients admitted, four were ready to be discharged to acute wards. This meant that the lack of availability of acute beds had an impact on the quality of care of women on ES1.

On Johnson Ward, we saw records that reflected there had been an incident when 11 patients were admitted to the ward as an additional patient had been brought to the ward and had been secluded before a patient had been transferred to the acute ward. We were also told of another situation where this had happened within the six months prior to our visit. We requested information from the trust about these incidents and how they were managed and were provided with assurance that this had been escalated when it had occurred. However, this meant that there was a risk that an intensive care ward may be over 100% occupancy and staff may not be able to manage the care of patients safely.

Facilities that promote comfort, dignity and privacy

Patients were provided with single rooms. There were shared toilet and bathroom facilities. There were sufficient rooms on the wards to ensure that patients had spaces to meet with staff privately and for there to be quiet areas as well as communal areas. Each ward had outside space and a garden area.

Patients' privacy was respected with the use of vision panels on bedroom doors. Where these were not able to be controlled by patients, patients could choose whether to have these open or closed.

There were areas on the ward where patients' possessions could be kept safely, including locks on bedroom rooms. On Croydon PICU patients had keys to their bedrooms. On other wards, patients were able to ask staff for access to their bedrooms.

Each ward had a space where visitors could come to the ward and each hospital site had specific areas for any family members under 18 who might visit the service.

ES1 had a sensory room which provided a calming space. This room included soft furnishings, light projections and could have music and video screened in. We saw this room in use. Patients and staff told us that they had benefited from this relaxing space on the ward. The ward environment on ES1 also included paintings commissioned specifically to enhance the appearance of the ward. This was a very positive environment for patients on ES1 and was appreciated by staff and patients.

Meeting the needs of all people who use the service

The service took account of patients' individual needs including needs relating to their cultural, religious and spiritual needs. The wards had access to a chaplaincy service which provided additional spiritual support to patients of a range of religious backgrounds and none. Patients had access to prayer mats if they required them based on their religion and staff had an understanding about how they would meet the needs of patients with a variety of religious backgrounds.

On Johnson Ward, we were given an example of a patient who was provided with Caribbean food when there were concerns about him not eating. This meant that the service was able to adapt to meet the individual needs of patients.

Staff were aware of the needs of patients who identified as lesbian, gay, bisexual and transgender. We were given examples of how patients were supported, for example, on Eden Ward, staff were aware of the additional safeguarding requirements in place when a patient who identified as gay was placed with a patient who was deeply religious and where there may have been tension between the patients. This meant that staff were able to demonstrate a sensitivity to the sexual orientation and gender identity of patients.

Staff across the service gave us examples of working with patients who had autism or learning disabilities who were being provided with support in the PICUs. At our previous inspection in August 2018 we identified that training for staff around autism in particular would provide a better service to patients. After our inspection, we were provided with a plan by the trust to deliver this training to staff working in the service.

Listening to and learning from concerns and complaints

Between 1 January 2018 to 31 December 2018 eleven complaints were raised from the PICUs. One of these was upheld and three were partly upheld.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Unknown	No further action identified	Withdrawn
Johnson Unit	4	1	1	1	1		
Eden ICU	3		1	1			1
ES1 Ward	3		1	2			
Croydon PICU	1				1		

Staff told us that they had a good understanding of complaints processes and were able to signpost patients to complaints procedures if they wished to make them. Information was available on all the wards which informed patients how to make complaints.

Feedback and learning from complaints were discussed in local governance meetings. Patients we spoke with told us that they knew how to complain, if they felt it was necessary.

Is the service well led?

Acute Wards

Leadership

Since the inspection in July 2018, there had been changes to the leadership of the acute wards. The trust had moved to a borough-based model of working, with separate senior managers leading ward teams at each hospital site. Staff told us that the move to a borough-based model of working had been a big improvement and staff felt senior managers had a greater presence on the wards. Senior managers told us they had an improved oversight of the wards they managed by completing regular quality walk arounds of the ward.

At the last inspection in July 2018, many wards did not have a permanent ward manager and/or there had been several changes of ward manager in the last year, which led to a lack of stability. Eight of the ward managers were in acting up or locum positions. One consultant was employed on a locum basis. At this inspection, there had been an improvement. Five of the ward managers were in acting positions. The trust had worked hard to recruit into these posts. However, on LEO Unit, there had not been a permanent ward manager since January 2018, and staff said this had impacted the stability of the leadership on the ward. However, the current interim ward manager was on a six-month secondment, and staff had been positive about their leadership and effect on the quality of the ward. Fitzmary 1, Wharton Ward and Gresham 1 did not have a permanent consultant psychiatrist in place, which had an impact on the consistency of leadership.

Of the leaders who were permanent in their role, they demonstrated a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care. For example, on Luther King Ward, the ward manager was well established in their role as a manager and led the team effectively.

Leaders were visible in the service and approachable for patients and staff. Staff and patients all knew who the ward managers were and said they would speak to the ward manager if they had any concerns. Most staff knew their senior managers within their borough directorates.

Leadership development opportunities were available for staff. For example, the ward manager on Eileen Skellern 2 was undertaking a leadership course. On Jim Birley Unit, the dual-diagnosis lead was taking a five-day course in relation to their role. Nursing staff across the wards had access to the nurse prescriber programme.

Vision and strategy

Staff knew and understood the provider’s vision and values and how they were applied in the work of their team. The visions and values were displayed throughout the wards and staff appeared committed to them.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. For example, where some wards had piloted long day shifts, managers had consulted with staff prior to the change in shift patterns. Also on Aubrey Lewis 2, managers had consulted with staff regarding planned refurbishments to the ward.

Staff could explain how they were working to deliver high quality care within the budgets available. Ward managers and senior managers had regular meetings where finances for the wards were reviewed and discussed.

Culture

Staff we spoke with said they felt respected, supported and valued by their colleagues. Staff said managers promoted a positive and open culture. Some staff told us there had been an improvement in the culture of the trust since our last inspection.

Most staff felt positive and proud about working for the trust and their team. However, some staff across the acute wards told us that they felt stressed and under pressure due to the shortages of permanent nurses, ward managers and psychiatrists in some teams.

Staff we spoke with said they felt about to raise concerns without fear of retribution. Staff said they would feel happy to raise concerns through their ward manager.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. Wards displayed information about speak up advocates.

Teams worked well together and where there were difficulties managers deal with them appropriately. For example, where wards had staffing difficulties, we saw evidence that all staff were involved in discussions around staffing through regular team meetings and kept up-to-date with what managers were doing to support wards.

Staff appraisals included conversations about career development and how it could be supported.

The provider recognised staff success within the service. For example, the trust put on an annual staff award event, which recognised the efforts and achievements of staff to improve the lives of patients. Staff also told us that they received messages of thanks from senior managers when they had managed difficult situations.

Governance

Services were managed through borough-based leadership teams.

The service had improved its governance systems since our last inspection. There was a clear framework of what must be discussed at ward and senior management level. For example, monthly ward staff meetings followed a clinical governance structure where pertinent issues such as incidents, complaints, best practice and performance data were discussed. These meetings then fed into the overall borough-wide clinical governance meetings. This had improved since the last inspection. In addition, ward managers met monthly to discuss governance issues such as the ward environment and staffing.

During the last inspection in July 2018, we told the trust that they must identify and provide timely support to wards and teams where standards of care needed to improve. During this inspection, we found that the trust had improved and implemented a number of initiatives to support the wards that needed to improve. These included Wharton Ward, Aubrey Lewis 2, LEO Unit and John Dickson Ward. For example, on Aubrey Lewis 2, managers had transferred an experienced matron into the ward manager position to lead the ward. This had a positive impact on the ward and improved standards of care. The trust had also employed clinical leads into key positions at each hospital site to provide leadership in the improvement strategy. For example, the modern matrons had a regular presence on the ward to carry out audits to assure the trust that quality was being maintained. This had led to less variation in the quality and safety of care and treatment being delivered between wards.

However, the trust still needed to continue with its recruitment and retention drive to address the staffing concerns. Most wards relied on bank and agency staff to ensure safe numbers of staff were on the wards. The trust needed to recruit into the five ward manager posts and three

consultant psychiatrist posts, which would strengthen the leadership and clinical governance of acute wards.

At the last inspection in July 2018, we told the trust that they must ensure that governance processes were sufficiently robust so that they identify where improvements needed to be made and ensure that action was taken to make the required improvements. At this inspection, we found that managers were more aware of the quality of care and treatment provided to patients in different wards. The trust had introduced effective systems to identify issues, but these systems still needed time to be fully embedded. Each ward had implemented monthly clinical governance meetings to address areas that needed to improve. This meeting was open to all staff on the ward, and items such as rapid tranquilisation and restraint were discussed. Managers also attended borough-based quality meetings to discuss performance and quality. Senior managers completed regular Quality, Effectiveness and Safety Trigger Tool (called QuESTT) assessments of each ward to identify if they needed extra support. The assessment looked at vacancy rates, bank usage, sickness rate and supervision rate. Leo Unit had a QuESST action plan in place to address these specific areas of concern. However, not all governance processes ensured that the necessary action was taken to make the required improvements. For example, it was not clear who was going to carry out identified actions in the environmental risk assessments on some wards.

Staff implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.

Staff undertook clinical audits and used these to gain assurance about the services provided. There were monthly and annual audit schedules in place which included the environment, care records, health and safety, clinic room, medicines management and Mental Health Act documentation.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. For example, staff had good relations with local social service providers, housing associations and care coordinators to ensure smooth discharge processes for patients.

Management of risk, issues and performance

The service maintained and had access to the risk register at borough level. Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. For example, staffing and environmental issues.

Each ward used QuESTT which identified key areas of risk within the service and identified actions to mitigate the risks identified. This process operated effectively to ensure that ward managers and staff on the ward were able to have clear timescales in which to meet any areas of performance where there were weaknesses. This also ensured that the local and trust wide leadership teams were able to identify any issues on the wards rapidly and address them to maintain a good quality of care. The key risks from the QuESTT were identified on the risk register so that priorities for actions could be taken.

The service had plans for emergencies – for example, adverse weather or a flu outbreak.

Where cost improvements were taking place, wards did not compromise patient care.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. None of the staff we spoke with raised concerns about data collection.

Staff had access to equipment and information technology needed to do their work. Wards had computers for staff to access electronic records. Wards also used tablet computers to record some observation and physical health checks. In some wards, when we visited, the tablets were not in use and a contingency was in place where records were collected manually, this meant that staff had an understanding of alternative ways of recording when IT systems were not operational.

Team managers had access to information which helped them to do their jobs, including staffing information like vacancy rates, appraisal rates and mandatory training records. Managers recorded supervision locally to ensure that they were able to monitor this locally.

Staff made notification to external bodies as needed. For example, the service reported serious incidents to the Strategic Information Executive Service at NHS Improvement.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. Staff had opportunities for engagement through information which was provided on the trust intranet including regular newsletters and email bulletins when there was specific information of direct relevance. Patients and carers had access to a variety of leaflets on the ward.

Patients had opportunities to feedback about the service through regular ward community meetings, multidisciplinary meetings and surveys.

Patients and carers were encouraged to complete family and friends' tests to provide the trust with feedback. Feedback was gathered through paper forms as well as online forms. Patient and carer feedback was discussed in local team meetings and borough-wide clinical governance meetings.

Managers and staff had access to feedback from patients, carers and staff and used it to make improvements. The ward notice boards on some wards displayed the 'we listen, we respond, we improve' posters which detailed improvements the hospital had made because of patient or carer feedback.

Patients and carers were involved in decision making about changes to the service through the trust's patient and carer advisory groups. Patients also sat on staff interviews.

Senior managers regularly engaged with staff through quality walk arounds and attending ward team meetings. Staff told us that senior managers were very visible and approachable. The senior management team had good relationships with external stakeholders, such as the local authority, other NHS trusts and independent hospitals.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation. For example, at the Maudsley Hospital, physical health leads were overseeing physical health audits on the wards, to ensure patient's physical health needs as well as their mental health needs were being considered. On Powell Ward, a student nurse had secured funding to purchase an aromatherapy machine for patients to use on the ward.

Some staff used quality improvement (QI) methods and knew how to apply them. For example. On Jim Birley Unit, staff were carrying out a QI project in relation to the efficiency of handover meetings using the situation, background, assessment, recommendation and decision (SBARD) technique.

On Virginia Woolf, staff had implemented a service change in June 2018 in relation to the change in triage model to an acute model. This led to a decrease in ward rounds to ensure that the multidisciplinary team were as effective as possible in the usage of their time.

Gresham 2 were re-applying for accreditation for inpatient mental health services (AIMS), after they received their last accreditation in 2017.

Psychiatric Intensive Care Units

Leadership

Staff we spoke with were positive about the input of their ward managers and the local borough level leadership. Some staff had a good awareness of the senior leadership teams in the trust and we heard about visits to the wards from executive board members including the chief executive officer and director of nursing.

All the ward managers of the PICUs were permanent, some had been recently appointed, and they told us that they felt supported in their role by their managers. Ward managers had a good understanding of the teams they managed, including the strengths and weaknesses in the operation of the wards.

Staff had opportunities to undertake training in leadership development and some of the ward managers had accessed this and hold us that they found it helpful.

Vision and strategy

Staff were aware of the provider's vision and values and reflected the trust values and pledges in the ways in which they worked with patients. We observed staff display a good understanding of delivering person-centred care and involving carers which reflected trust objectives.

Information was available for staff about the trust values, aims and strategy on the intranet and on posters throughout the hospital sites.

Culture

Staff we spoke with told us that they felt supported by their managers at a ward and borough level as well as throughout the trust. They told us that they felt able to raise concerns if any were identified.

Most staff we spoke with were positive about the trust as an employer and felt they were able to share feedback about services in which they worked which was valued by the organisation.

Ward managers told us that they had good links with human resources teams when they needed to have information about managing staff. They had access to specific training relating to management of staff. They felt equipped and supported to manage performance if necessary.

Governance

The service used a systematic approach to continually improve the quality of care on the PICUs and ensuring that there was a priority of issues where there were the most significant levels of concern.

Each ward had regular staff meetings which had a standard agenda and included issues relating to clinical governance such as feedback relating to incidents, complaints and patient feedback. This identified areas where it was possible to improve the quality of care. Boroughs had local clinical governance meetings where ward managers were able to share information across the wards on the sites in which they worked.

Each ward had a programme of audits including infection control, environmental (including ligature risk management) and medication audits including physical health monitoring after the administration of rapid tranquillisation. This ensured that the provider had oversight of the performance of the ward and that the ward staff knew areas where they needed to improve and where they were working well.

Services were managed through borough-based leadership teams. This meant that each PICU was managed locally and linked to the associated acute wards. However, ES1, which was based at the Maudsley Hospital, covered female patients across the four boroughs. This meant that information which was relevant to ES1 was held across the four boroughs. The borough governance processes were still embedding across the service but the structures were in place to ensure that quality and risk were managed.

Wards had systems of audit in place and audits were reviewed by the local governance teams. Each borough leadership team reported to the trust-wide clinical governance committees to ensure that information was shared appropriately across the teams.

The service had a combined operational policy which covered the four PICUs. This ensured there was an expected consistency of the operation of the units across the four boroughs.

Management of risk, issues and performance

Each ward used a Quality, Effectiveness and Safety Trigger Tool (called QuESTT) which identified key areas of risk within the service and identified actions to mitigate the risks identified. This process operated effectively to ensure that ward managers and staff on the ward were able to have clear timescales in which to meet any areas of performance where there were weaknesses. This also ensured that the local and trust wide leadership teams were able to identify any issues on the wards rapidly and address them to maintain a good quality of care.

Each borough held a risk register which pulled the key risks from the QuESTT so that priorities for actions could be taken. In Lambeth, we identified a risk which had been raised following an incident in January 2019 had been added to the borough risk register in March 2019. This meant that there was a potential delay in some aspects of concern being escalated to the formal risk register. Staff on the ward and the borough leadership had a good understanding and knowledge of the risks which had a potential impact on performance.

Information management

Staff had access to equipment and information technology needed to do their work. Wards had computers for staff to access electronic records. Wards also used tablet computers to record some observation and physical health checks. In some wards, when we visited, the tablets were not in use and a contingency was in place where records were collected manually, this meant that staff understood alternative ways of recording when IT systems were not operational.

Team managers had access to information which helped them to do their jobs, including staffing information like vacancy rates, appraisal rates and mandatory training records. Managers recorded supervision locally to ensure that they were able to monitor this locally.

Engagement

Patients had opportunities to feedback about the service through regular ward community meetings. Staff had opportunities for engagement through information which was provided on the trust intranet including regular newsletters and email bulletins when there was specific information of direct relevance.

Patients and carers were encouraged to complete family and friends' tests to provide the trust with feedback. Feedback was gathered through paper forms as well as online forms. Patient and carer feedback was discussed in local team meetings and borough wide clinical governance meetings.

Learning, continuous improvement and innovation

ES1 had achieved accreditation through the Royal College of Psychiatrists scheme. Johnson ward and Eden Ward told us that they had started the process of seeking the same accreditation.

Staff across all the sites we visited spoke to us enthusiastically about the trust quality improvement projects which they were involved in and were able to give us examples of improvements they were working on. For example, on ES1, there had been work around improving the environment including the sensory room which had been received very positively. On Croydon PICU staff told us that they had worked extensively to reduce blanket restrictions including the use of mobile phones on the ward and ensuring that patients had bedroom keys. There was an appetite for improvement among the staff we spoke with.

The services were members of the national association of psychiatric intensive care units (NAPICU). This was a national organisation which sought to share good practice and learning. This meant that the teams were provided with support to learn across other psychiatric intensive care units and were able to benefit from this membership.

Accreditation scheme	Service accredited	Comments
AIMS – PICU (psychiatric Intensive Care Units	Eileen Skellern 1 Ward (Southwark)	

Long stay/rehabilitation mental health wards for working age adults

Facts and data about this service

Location site name	Ward name	Number of beds	Patient group (male, female, mixed)
Lambeth Hospital	Tony Hills Unit (THU)	15	Male
Bethlem Royal Hospital	Westways	18 (9M/9F)	Mixed
Heather Close	Heather Close	16 (8M/8F) 8 (M)	Mixed

Is the service safe?

Safe and clean environment

Safety of the ward layout

Staff undertook regular risk assessments of the care environment, conducting environmental checks every hour. Staff recorded and reported on any areas that required attention, for example spillages or broken items of equipment.

The ward layouts varied across the three units. Each of the wards had some blind spots, although convex mirrors had been installed to mitigate the risks as far as possible. The manager at Heather Close had ordered additional convex mirrors to ensure all blind spots were covered. Some of these had been fitted and others were still on order.

There were some ligature risks on all the wards, but these were managed safely. Each ward had completed its own ligature risk assessment. Most staff were aware of the ligature points and followed plans to reduce the risk of them being used. At the last inspection in September 2015, we found that the physical environment at Heather Close had some high-risk ligature points as well as patients who may harm themselves and did not have appropriate systems in place to mitigate these risks. During this inspection, we found that improvements had been made. Ligature risk assessments had been updated and there were photographs of key ligature points placed on the staff notice board to help staff identify them. The induction checklist for temporary staff at each of the three locations had been updated to ensure these staff were made aware of the ligature points. Staff mitigated the risks of ligature points by completing patient risk assessments and conducting continuous or intermittent observation on patients who required this. Most staff we spoke with were able to describe to us where ligature points were, although one member of bank staff at Heather Close was unable to identify any ligature points on the unit. We noted that there was one ligature risk at Westways, which had not been identified on the ligature risk assessment, the wire on a fridge temperature monitor located in the patients' beverage kitchen. We informed the ward manager who assured us this would be addressed immediately.

The wards complied with guidance on eliminating mixed-sex accommodation. All patients had their own bedrooms. Tony Hillis Unit was a male only ward, patients had shared bathroom and toilet facilities. Westways was mixed gender. Male and female areas on Westways were segregated by key controls. Patients had shared bathroom and toilet facilities, which were within the male and

female segregated areas. Heather Close had one male only unit as well as one mixed-sex unit. At the previous inspection in September 2015, we found that staff at Heather Close did not always ensure that male patients did not enter the bedroom areas of females and vice versa. During this inspection, we found that a swipe card system had been installed for patient use so that males and females only had access to their own bedroom area. All bedrooms at Heather Close were ensuite. Staff understood the importance of ensuring bedroom areas remained segregated.

Staff had easy access to alarms and patients had easy access to nurse call systems. All units had wall-based panic alarms. At the Tony Hillis Unit, staff also used a handheld alarm due to the increased acuity of the patient group. The manager at Westways was in the process of purchasing handheld alarms as the acuity of the patient group had steadily increased over time.

A fire risk assessment was carried out on each of the units in 2018. The risk assessments were supported by action plans, some of which were ongoing. The trust undertook weekly fire alarm tests and fire drills each ward every six months. A record was maintained of how long the evacuation took as well as any issues identified during each drill. However, it was noted that at Heather Close, where some patients refused to leave the building, no action was recorded as to how these patients should be supported in the event of a real fire. Staff said they had received fire safety training. At the last inspection in September 2015, we observed on Heather Close that fire doors were wedged open and blocked with furniture and fire extinguishers did not have signage. During this inspection we found no evidence of fire doors being wedged open. There were fire extinguishers available on all the units with the correct signage displayed. They were kept in locked rooms. All staff knew where the extinguishers were kept and had a key to access these rooms.

There were no seclusion rooms on the wards. Tony Hillis Unit had a separate area, which could be used by staff for de-escalation. We were informed by the ward manager that this room was rarely used, as incidents of violence and aggression were very low. The manager said that discussions were being held with senior management to decommission this room and convert it into a sensory room for patients.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well-maintained. The ward environments were visibly clean and clutter free. Each unit had dedicated domestic staff responsible for cleaning. Staff and patients said that the levels of cleanliness on the wards were good. However, some staff and patients at the Tony Hillis Unit complained that the toilets were regularly blocked.

The patient led assessments of the care environment (PLACE) survey were carried out in 2018. PLACE scores were calculated at a site level and included all wards at a given site. The Bethlem Royal Hospital, where Westways was located, scored higher than the England average for cleanliness as well as condition appearance and maintenance. Lambeth Hospital, where Tony Hillis Unit was located, scored higher than the England average for cleanliness and slightly lower than the England average for condition appearance and maintenance. The units at Heather Close scored lower than the England average for both of these elements in the PLACE survey.

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
LAMBETH HOSPITAL	Acute wards for adults of working age and psychiatric intensive care units	98.3%	92.8%

Site name	Core service(s)	Cleanliness	Condition appearance and maintenance
	Long stay/Rehabilitation mental health wards for working age adults		
BETHLEM ROYAL HOSPITAL	Acute wards for adults of working age and psychiatric intensive care units Long stay/Rehabilitation mental health wards for working age adults	99.5%	97.9%
1-5 HEATHER CLOSE	Long stay/Rehabilitation mental health wards for working age adults	88.9%	74.4%
Trust overall		**98.6%**	**95.6%**
England average (Mental health and learning disabilities)		**98.4%**	**95.4%**

At the last inspection in September 2015, repairs reported to the trust maintenance team were not carried out in a timely manner at Tony Hillis Unit and Heather Close. During this inspection we found that most repairs were carried out promptly and in accordance with the urgency of the request.

Staff adhered to infection control principles, including handwashing and wearing appropriate personal protective equipment such as disposable gloves.

Clinic room and equipment

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff kept an emergency grab bag containing lifesaving equipment in the clinic rooms. Staff undertook checks to ensure all items within the bag were kept in line with trust policy. At the last inspection in September 2015, we found that Heather Close did not have a defibrillator on each of the units. During this inspection, we found that there was a defibrillator for each unit. Records showed that staff checked emergency equipment weekly. There was an emergency drug box in each clinic room. At the last inspection in September 2015, we found that ligature cutters were not immediately available for all units at Heather Close and staff at the Tony Hillis Unit were uncertain where they were stored. During this inspection, we found that improvements had been made, ligature cutters were available on each unit and staff knew where they were stored.

Staff maintained medical equipment stored in the clinic rooms. Equipment was labelled with the date it was last checked and calibrated.

Staff cleaned equipment after use and weekly in line with a cleaning schedule. Staff kept records of cleaning checks. However, we found that the fridge in the clinic room at number 1 Heather Close was dirty. We raised this with staff who responded promptly and immediately cleaned the fridge.

Staff used a yellow plastic bin to dispose of needles and sharps. The yellow bins in the treatment rooms were dated on opening, and not over-filled at most of the units. However, we observed that the yellow bin at 1 Heather Close was overfilled beyond capacity, making it unsafe. We informed the manager who replaced this promptly.

Safe staffing

Nursing staff

Managers had calculated the number and grade of registered nurses and non-registered nurses required on each shift. The number of registered nurses and non-registered nurses matched this number on most shifts. Managers and staff on all units reported that there were sufficient staff deployed on each shift to keep patients safe.

Managers were aware of their vacancies and recruitment to fill vacant posts was ongoing. At the previous inspection in September 2015, we found that basic staffing levels were met through a mixture of permanent and temporary staff due to vacancies and sickness, but that staff felt they were not supported by senior management regarding the challenges with staffing. During this inspection, we found that there were no vacancies at Tony Hillis Unit. Heather Close had recruited to most positions, but vacancies remained a challenge for Westways. Staff and managers felt supported by senior management, in their approach to ensuring wards were staffed safely.

The trust had worked hard to reduce vacancy rates and ran ongoing recruitment programmes. In December 2018, Heather Close had the highest vacancy rate for registered and non-registered nursing staff at 29% and 15% respectively. At the time of inspection, the manager at Heather Close informed us that staff had been appointed to all registered and non-registered nursing positions.

The vacancy rate at Westways for registered nursing staff was 17% as at 31 December 2018. The manager informed us this had increased, and recruitment was ongoing, there were four vacancies for band 5 nurses, two of which had been recruited to. The ward was safely staffed with the use of regular bank nurses and permanent staff working additional shifts.

Location	Ward/Team	Registered nurses			Non-registered nurses			Overall staff figures		
		Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)	Vacancies	Establishment	Vacancy rate (%)
Bethlem Royal Hospital	Westways	1.9	10.9	17%	-1.6	10.6	-15%	0.3	24.2	1%
Heather Close	Heather Close	6.8	23.6	29%	6.7	29.7	23%	14.9	55.7	27%
Lambeth Hospital	Tony Hillis Unit (THU)	-1.6	15.6	-10%	1.6	12.3	13%	-0.8	30.5	-3%

When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. When bank staff were used they were staff who came to the wards regularly and were familiar with patients and ward routines. All units we visited had high levels of bank staff use to ensure the agreed numbers of staff were present. The main reasons for bank and agency usage for the units were vacancies and sickness. Between the period 1 February 2018 and December 2018 Westways had the highest usage of bank staff at 25% of all shifts for registered nursing staff and Tony Hillis reported the highest usage of non-registered nursing bank staff at 86%.

Registered nursing staff

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Heather Close	42660	4812	11%	45	<1%	99	<1%
Tony Hillis Unit (THU)	27424	4979	18%	40	<1%	154	1%
Westways	19484	4812	25%	78	<1%	243	1%

Non-registered nursing staff

Wards	Total hours available	Bank Usage		Agency Usage		NOT filled by bank or agency	
		Hrs	%	Hrs	%	Hrs	%
Heather Close	48011	26358	55%	0	0%	142	0%
Tony Hillis Unit (THU)	20613	17642	86%	0	0%	192	1%
Westways	17925	10854	61%	0	0%	320	2%

When bank and agency nursing staff were used, those staff received an induction to familiarise them with the ward. The bank or agency nurse completed a checklist to demonstrate they had been inducted to the ward.

There was always a permanent member of staff on shift and we observed sufficient cover by nurses present in the communal areas of the wards.

Patients escorted leave, one to one sessions with named nurses and ward activities were rarely cancelled because there were too few staff. Patients said they could have one to one time with their named nurses most of the time and could speak to any member of staff when needed.

Staff turnover for the units averaged at 11% between 28 February 2018 and 31 December 2018 with the highest turnover reported by Heather Close at 17%.

Location	Ward/Team	Substantive staff (at latest month)	Substantive staff Leavers over the last 12 months	Average % staff leavers over the last 12 months
Heather Close	Heather Close	40.8	7.6	17%
Bethlem Royal Hospital	Westways	24.9	2.0	9%
Lambeth Hospital	Tony Hillis Unit (THU)	31.3	1.6	5%

Two of units had a higher than average sickness rate, Tony Hillis Unit was the highest at 9%; Heather Close 6.1% and Westways the lowest at 4.7%. Ward managers supported staff who had frequent or long-term sickness following the trust's sickness management process.

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Lambeth Hospital	Tony Hillis Unit (THU)	6.1%	9.0%

Location	Ward/Team	Total % staff sickness (at latest month)	Ave % permanent staff sickness (over the past year)
Heather Close	Heather Close	4.0%	6.1%
Bethlem Royal Hospital	Westways	3.2%	4.7%

Medical staff

There was adequate medical cover day and night and a doctor could attend the wards quickly in an emergency. Teams could access a consultant psychiatrist promptly when they needed one. Medical cover on each ward was provided by a consultant, either with support from a ward doctor and/or a specialist doctor. Staff told us that there was adequate medical cover to meet the needs of patients.

Ward staff had access out of hours to a duty doctor and consultant. A doctor could attend the ward quickly in an emergency.

Mandatory training

Most staff said they were up to date with mandatory training or booked onto the next available sessions for particular topics. The compliance for mandatory and statutory training courses at 31 December 2018 was 84%. Of the training courses listed 16 failed to achieve the trust target and of those, five failed to score above 75%.

The trust set a target of 85% for completion of mandatory and statutory training, 95% for information governance training.

Training is reported as a final figure as at the date given.

The training compliance reported for this core service during this inspection was higher than the 74% reported in the previous year.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✘	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Moving and Handling - Loads - Group 3	13	13	100%	✓	↑
Infection Control Level 1	13	13	100%	✓	↑
Basic Life Support - Group 1	5	5	100%	✓	↑
PSTS Awareness/Conflict Resolution	1	1	100%	✓	N/A
Safeguarding Children Level 1	5	5	100%	✓	↑
Safeguarding Children Level 3	5	5	100%	✓	↑
Safeguarding Children Level 1 and 2	88	85	97%	✓	↑
Health, Safety and Welfare	93	87	94%	✓	↑
Information Governance	93	86	92%	✘	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Equality, Diversity and Human Rights	93	85	91%	✓	↑
Prevent Workshop	88	79	90%	✓	↑
Mental Health Act Training	41	37	90%	✓	↑
Dual Diagnosis - Level 1	41	37	90%	✓	↑
Moving and Handling - Patients - Group 2	80	71	89%	✓	↑
Basic Life Support - Group 2	48	42	88%	✓	↑
Clinical Risk	88	77	88%	✓	↑
Fire Safety Awareness	93	81	87%	✓	↑
ASCOM	31	27	87%	✓	↑
Safeguarding Adults Alerters Plus	88	76	86%	✓	↑
Fire Warden	26	22	85%	✗	↑
Mental Capacity Act (MCA)	49	41	84%	✗	↓
Infection Control Level 2	80	66	83%	✗	↑
Immediate Life Support	40	33	83%	✗	↑
PSTS Team Work	83	68	82%	✗	↑
Deprivation of Liberty Safeguards (DoLS)	88	71	81%	✗	↑
Smoking Cessation Level 1	88	71	81%	✗	↑
Safeguarding Adults Alerters	5	4	80%	✗	↑
Clinical Supervision	14	11	79%	✗	↓
PSTS Disengagement	9	7	78%	✗	↑
Smoking Cessation Level 2	3	2	67%	✗	↑
NEWS	80	53	66%	✗	N/A
Prevent Awareness	5	3	60%	✗	↑
MEWS	79	31	39%	✗	↑
Health and Safety for Managers	11	2	18%	✗	↓
Total	**1667**	**1397**	**84%**		↑

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection, we reviewed the risk assessments of 10 patients across all three units. Staff had completed a risk assessment for every patient on admission and updated it regularly for most patients, including after any incident. Staff at each of the units formally reviewed risk assessments at care planning meetings and ward rounds and updated them every one to three months, including after any incident involving the patient.

Staff used a standard risk assessment tool. Staff prepared a risk management plan for each patient. Each risk management plan set out the risks that were specific to the patient and gave details of how staff could respond to these risks. Risk assessments were individualised and considered the patients' mental well-being, for example, their risk of harm to themselves or others or being sexually inappropriate. However, we noted that the risk assessments for two of the

patients at Tony Hillis Unit had not been completed in relation to some elements of their physical healthcare, for example diabetes and risk of seizure.

Staff identified risks which may result in a setback of a patient's progress and documented how the patient would be supported. For example, a risk assessment for self-harm for one patient recorded that when the patient felt the urge to self-harm, they would inform staff and discuss this with them.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Staff discussed any changes in patients' behaviour at daily handover meetings and reviewed risks for each patient at multidisciplinary meetings. We observed handovers as well as a multidisciplinary meeting and a ward round and found them to be effective.

Staff told us that detained patients who went absent without leave (AWOL) usually returned or made contact and came back on their own accord. Only patients with higher risk were being reported to the police. At the previous inspection in September 2015, we found that the wards did not have photographs of patients on file so that if they went absent without leave they could show the police what the patient looked like. During this inspection, we found that staff at each of the units had not consistently saved photographs of the patient to their record.

Each of the units were using the trust's 'four steps to safety' programme, although there were some elements which had not yet been fully implemented. The programme has four steps, which are based on clinical interventions, proactive care, patient engagement, teamwork and environment, and there were multiple interventions within each step. The aim of the programme was to reduce violence and aggression on the wards. Managers spoke positively about four steps to safety and understood its purpose. They told us that this had helped to maintain a calm ward and minimise the risk of violent and aggressive situations occurring. Each unit had embedded zoning which formed part of the proactive care step. Staff were also undertaking intentional rounding as part of patient engagement. The Dynamic Appraisal of Situational Aggression (DASA) tool part of the pro-active care step, had been rolled out across the acute inpatient wards but not all of the rehabilitation units. DASA is a tool to support the prediction of violence and aggression. We were informed by managers that it was planned to extend this to the Tony Hillis Unit and Westways later in the year because the acuity of patients had increased. Heather Close had trialled this tool, but the patients risk score was repeatedly 0, therefore it was discontinued.

Staff said they regularly checked patients' vital signs and recorded these on a National Early Warning Score (NEWS) chart. NEWS is a tool developed by the Royal College of Physicians, which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. Staff knew when and how to escalate concerns about NEWS scores. However, at Tony Hillis Unit, clinical observations for each patients NEWS score were taken in a separate treatment room adjacent to the clinic room (other wards had a combined treatment and clinic room) due to lack of space in the clinic room. One member of staff carried out the observations in the treatment room, informed the patient of their results and instructed the patient to relay this information to the nurse in the clinic room who would record them in the patient record. This meant there was scope for an error of recording. Patient monies were also distributed from the clinic room once all patients had received their medication. This meant that patients loitered in the area whilst others received their medication, possibly distracting the nurse administering medicines and compromising patient privacy.

Staff followed policies and procedures for the use of observation and for searching patients or their bedrooms. Staff completed observation records for each patient in accordance with trust guidance. At the previous inspection in September 2015, we found that staff at Heather Close were unsure about whether patients were supposed to be on enhanced observation or not. During this inspection, the manager informed us patients rarely required enhanced observation but that staff had been reminded about their responsibilities should the need arise. Staff knew the levels of observation patients were on. At Westways, staff conducted patient searches in accordance with individual patient risk. Staff at Heather Close and Tony Hillis Unit staff said that all patients were searched on their return from unescorted leave. Staff said they had received training on how to conduct searches.

Staff were working to reduce blanket restrictions but there was further work to do. At the previous inspection in September 2015, we found that staff applied blanket restrictions at Tony Hillis Unit as well as Heather Close. Patients at Tony Hillis Unit did not have access to facilities where they could make hot drinks and there was restricted access to the garden. At Heather Close, takeaways were not permitted after 7pm. Informal patients were also instructed to return to Heather Close by 8pm each day. During this inspection we found that some improvements had been made. Patients at all units could make drinks 24 hours per day and the limit on takeaways had been lifted.

Staff at the Tony Hillis Unit did not have a consistent understanding of restrictions imposed on patients or restrictions that had been recently lifted. They gave different accounts when explaining the restrictions in place. For example, one member of staff said that all patients could keep their mobile phones with them and another said they that patients were individually risk assessed to determine whether they could safely keep their phones with them. A third said that all mobile phones were kept in a locker in the unit. Patients could use their phones outside but had to place them in the locker on their return. They said this restriction was to be lifted and mobile phones would be given to patients once a delivery of phone chargers with a short lead was received on the ward. The ward manager informed us that these changes were already in place. Staff said that a blanket restriction on patients obtaining take-away meals had recently been lifted. Patients could get a takeaway whenever they wanted. Staff said they did not agree with the lifting of the restriction because it had a detrimental effect on patients' physical health in terms of weight gain. They reported many patients were getting takeaways every day. Staff at Tony Hillis Unit also informed us that patients could only access the garden until 8pm, the manager informed us the garden was locked at midnight for security purposes.

Staff adhered to best practice in implementing a smoke-free policy. Patients were able to purchase e-cigarettes onsite. Other nicotine replacement therapies were also available.

Most patients did not have a personal emergency evacuation plans to follow in the event of a fire or other emergency. Staff informed us that the patient group did not require a personal emergency evacuation plan because none of the patients had physical disabilities. However, it was clear in fire drills at Heather Close that some patients had refused to leave the building, therefore there was a risk that in the event of a real fire, the lives of patients and staff could be endangered if adequate systems are not in place. One patient at Heather Close had a personal emergency plan in place, this informed staff what action to take in relation to this patient in the event of a fire. However, not all the staff knew of this plan.

Use of restrictive interventions

There were no reported incidents of seclusion or long-term segregation.

We were informed by the ward managers that restraint rarely occurred. There had not been any restraints at Westways, and one at Tony Hillis. Two incidents of restraint were reported at Heather Close. The incidents had been reported following the trust's incident reporting procedure. However, staff had not recorded details of how the restraint took place such as which member of staff held which part of the patient's body.

Staff used restraint only after de-escalation had failed and used the correct techniques. The wards in this service participated in the provider's restrictive interventions reduction, the 'safe wards' programme. The 'safe wards' programme aimed to reduce conflict and incidents on hospital wards. The programme recommended specific actions for staff in response to potential triggers to incidents. Staff had been trained in physical interventions as part of their mandatory training. This meant that staff had the required skills to deescalate patients who became aggressive to minimise the use of applying restrictive interventions. Staff had also been trained in how to restrain people safely and knew to avoid restraining people in the prone position where possible.

There were no reported incidents, which required the use of rapid tranquilisation.

Safeguarding

Staff were trained in safeguarding and knew how to make a safeguarding alert and did that when it was appropriate. As of 5 March 2019, over 93% of staff were trained in safeguarding adults and children at levels 1, 2 and 3 across the unit.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies. Staff could give examples of safeguarding alerts they had made. This core service made 45 safeguarding referrals between 1 February 2018 and 31 December 2018. Staff completed records of safeguarding referrals and submitted them to the local authority safeguarding team. Staff put protection plans in place to keep patients safe.

Staff followed safe procedures for children who visited the units. The trust had a policy in place for visits from children and staff were aware of this. Visits from children were rare but rooms were available outside of the units for this to take place.

Staff access to essential information

Staff used an electronic system to document patient records. However, the system was very slow, this meant that staff spent unnecessary amounts of time reviewing and updating patient records.

Most information was recorded on the electronic patient record. Some information, such as the results of blood tests, electrocardiogram results and records of other physical observations were held in paper records and subsequently scanned onto the system.

All information needed to deliver patient care was available to staff when they needed it and was in an accessible form. All clinical staff employed directly by the trust, including permanent and bank staff, had access to the electronic system. This included when patients moved between teams. All teams across the trust recorded information on the same electronic patient record system. Staff were familiar with this system. Staff used this system to record and access each patient's progress notes, care plan, risk assessments and other information relating to their care and treatment.

Medicines management

Staff followed good practice in medicines management. Staff ordered, stored, dispensed and disposed of medicines safely. However, it was noted that at 1 Heather Close, cupboards were overstocked with medication. Cupboard space was limited and the pharmacist visited the service

once every two weeks. This meant that medication cupboards were stocked to capacity including non-controlled drugs being stored in the controlled drugs cupboard, which made it difficult for staff to find the required patient medication easily. We found some out-of-date medication in the cabinet, we reported this to the manager who arranged for immediate disposal of the out-of-date items.

Staff reviewed the effects of medicines on patients' physical health regularly and in line with the National Institute Health and Care Excellence (NICE) guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Staff monitored the side effects of medicines using an antipsychotic side-effects measurement scale. The trust maintained a register of patients receiving antipsychotic medication above the limits set out in the British National Formulary (BNF). The trust also maintained a separate register of patients prescribed lithium. Each of the registers showed the dates on which clinicians had last carried out blood tests, electrocardiograms, and liver function tests. If these tests had not been completed within the last six months, the register would automatically send alerts to the consultant psychiatrist reminding them to arrange for these tests to be carried out. However, we noted that at Heather Close the BNF in each clinic room was out of date.

Staff checked controlled drugs and fridge temperatures daily. Records for most units showed that fridge temperatures were within permissible limits. However, we identified that the documented fridge temperatures on at Heather Close had, on occasion been lower than the minimum recommended temperature and staff had failed to escalate this.

We reviewed the medicine administration records for 50 patients in the three units. Most of the records were completed appropriately. Staff signed when they administered medicines or recorded why not, although we noted that staff had not signed the administration records for two patients at Heather Close. Staff noted allergies and potential adverse reactions on the patients' records. The prescriber gave staff clear directions about when staff should administer 'as required' medicines.

Audits of medicines administration records were completed each month.

Track record on safety

Between 1 January 2018 and 31 December 2018 there was one serious incident reported by this service, this was on the Tony Hillis Unit. Other units had not reported any serious incidents.

	Number of incidents reported	
Type of incident reported (SIRI)	**Pending review**	**Total**
Tony Hills Unit, Rehabilitation Service	1	**1**

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. Staff reported all incidents they should report. Staff said there were very few incidents on the wards, but they knew what, when and how to complete an incident report.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.

Staff met to discuss feedback from incidents although this process was still new and not well embedded. Incidents were discussed at the handover meetings and were also a standing agenda item on the newly rolled out monthly governance meetings. However, there was limited evidence in the minutes of the meetings, which had taken place so far, that the content of and learning from incidents had been discussed.

Staff were aware of a serious incident which had occurred on their own ward. Staff on the Tony Hillis Unit were aware of the unexpected death of a patient on the ward in 2018 and the cause of death. Staff on each unit said they were told about incidents in other services across the trust by their manager. They found it hard to describe any learning from incidents.

Ward managers reviewed incident reports and completed an investigation where required. Serious incidents were escalated to senior management and reported to the appropriate external organisations.

Staff were debriefed and received support after a serious incident. The manager told us that staff were well supported following an incident and some staff accessed the available counselling.

Staff made changes because of feedback from initial incident investigations. For example, Tony Hillis Unit reported one serious incident in the preceding 12 months and the frequency of environmental checks had increased as a result. The manager at Heather Close told us about a recent medication error where one patient had self-administered more than their prescribed dose whilst on leave due to a dispensing error. The manager informed us that medication checks were now performed by two members of staff before a patient went on leave.

Is the service effective?

Assessment of needs and planning of care

We reviewed 10 patient care and treatment records during our inspection. Most records demonstrated good practice in terms of assessment, treatment and risk management. However, there was little information around rehabilitation provided with a view to discharge. This meant that most patients did not have achievable goals designed to support their recovery.

Staff completed a comprehensive mental health assessment of patients in a timely manner at, or soon after, admission. Most admissions to these units were planned transfers from other mental health wards. A few patients were transferred from the community into Westways. Staff carried out an assessment prior to each admission to ensure the patient was suitable for rehabilitation.

Staff assessed patients' physical health needs in a timely manner after admission and documented the frequency of follow-up checks required.

Staff developed care plans that met patients' individual needs. At the previous inspection in September 2015, we found that care plans were not frequently reviewed and did not contain all relevant information. During this inspection we found that improvements had been made. The care plans we reviewed were individualised and mostly comprehensive. However, they did not include achievable recovery goals and relevant support for patients to work towards these goals.

Staff updated care plans when necessary. Staff regularly reviewed patient care plans and involved the patient and their family or carer in this process. At Westways and Tony Hillis Unit patients' views were recorded in the patient records but we found little evidence of this in the care plans of patients at Heather Close. However, there was good evidence that patients were involved with their care through chairing their review meetings.

Best practice in treatment and care

Patient care records showed that staff following NICE guidance, in some aspects of care and treatment, although there was limited evidence around access to psychological interventions at Heather Close in particular. Records showed that psychiatrists prescribed appropriate medicines. Occupational therapists and activity workers provided some rehabilitation activities for daily living at each of the units.

Staff focus on providing recovery and rehabilitation varied across the service and between the three units. Westways had adopted the recovery star model, which was a means to support patients to manage their mental health on their pathway to recovery. Staff at Westways described themselves as somewhere between a high dependency and community unit, although the manager informed us that the patient group was increasingly leaning towards a high dependency unit. Staff at Westways supported patients to develop the skills necessary to manage their own medicines and self-medicate. Staff supported patients to self-administer medicines by adopting a staged approach whereby they were initially closely supervised supervision until they were ready to look after their own medicines and self-administer in their own bedrooms. Patients were provided with locked cabinets to store medicines safely.

There were no patients at Tony Hillis Unit or Heather Close being supported to manage their own medicines in preparation for discharge, although the service had safe storage facilities for patients to keep their medicines in their bedrooms. The Heather Close consultant psychiatrist said the service was prevented from implementing a self-administration of medicines programme by a lack of appropriate pharmacist support.

Staff supported patients with self-care and some basic supervised cooking skills, shopping for their cooking activities as well as support with budgeting. However, this was not sufficient to support patients to be fully self-catering. Patients at Heather Close could also attend regular classes to develop their basic literacy and numeracy skills. Both units defined themselves as high dependency units and therefore the degree of recovery provided may have lower thresholds. However, structures or pathways for rehabilitation had not been clearly defined to ensure patients continued to develop and improve their degree of independence.

Staff at all units supported patients to clean their own bedrooms. Each week patients and staff cleaned bedrooms together. Staff encouraged patients to keep their rooms tidy each day with a thorough clean once each week.

Patients at all units were supported by the occupational therapists to use the activities in the daily living kitchen. Patients required an assessment before they could use this. All cooking was supervised and therefore restricted in terms of the amount of time patients could spend cooking. Patients at Westways had a Saturday lunch group where they were supported by staff to make a simple lunch for themselves.

Staff directed patients to other services when appropriate and, if required, supported them to access those services. Staff had supported one patient to attend the recovery college at the Bethlem Royal Hospital, another patient was being supported to attend IT classes and another to learn about hospitality.

Patients at Westways and Tony Hillis Unit had support from a clinical psychologist. Tony Hillis Unit had support from a clinical psychologist, three days per week as well as an assistant psychologist. Westways had support from a clinical psychologist, two days per week. The clinical psychologists and assistant provided cognitive behaviour therapy (CBT) for psychosis, narrative approaches, stress tolerance and other psychological interventions. However, at Heather Close there had not been a clinical psychologist in post for nine months and the service was unable to provide several

clinically indicated psychological therapies, such as CBT for psychosis. The service had obtained agreement for the hours of the clinical psychologist post to be increased to full time (from two days) to make it easier to recruit and provide therapeutic interventions recommended by NICE.

At Tony Hillis Unit, the assistant psychologist helped facilitate a group in conjunction with the forensic personality disorder community team to support patients with substance misuse problems alongside their mental health problems. This group used a behavioural treatment for substance misuse model, an evidence-based harm-reduction approach, which involved payments for patients who attended groups. Group evaluation measures showed a decrease in the number of patients going absent from the ward and a reduction in illicit drug use by participants.

All units had support from an occupational therapist. Westways and Heather Close had two full-time occupational therapists. One of the occupational therapist posts at Heather Close was vacant but cover was being provided by a locum. Tony Hillis Unit had one occupational therapist who worked four days per week.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. All patients were registered with a local GP. The GP would visit the service to see those who could not come to the surgery. Patients with long-term health conditions were referred to other secondary healthcare services when required. Eight patients at Heather Close with long-term health conditions had health passports which had been co-produced with staff. These explained the patients' physical health problems in plain English and in pictorial form to make it easier for patients to have meaningful conversations with health professionals and others about their health. Westways had plans in place to learn from Heather Close and adopt a similar practice.

Staff supported patients to attend appointments at other hospitals in relation to their physical health when required. There was good evidence on patient files of communication between the medical and nursing staff at the unit and the hospital staff responsible for meeting the patients' physical health needs.

Staff assessed and met patients' needs for food and drink and for specialist nutrition and hydration. Some patients at each of the units had a diagnosis of diabetes. Staff supported patients to make the right food choices to ensure they maintained good health, although some staff at the Tony Hillis Unit expressed concern regarding the number of takeaway meals patients purchased.

Staff supported patients to live healthier lives in relation to smoking and substance misuse. Staff also supported patients to be active. The smoking cessation lead for the trust attended ward rounds and spoke with patients about stopping smoking. A range of nicotine replacement therapies were provided. Patients could use electronic cigarettes on the ward.

The Tony Hillis Unit had gym equipment (a mini-gym), but this was not often used. Patients needed to be referred to the gym instructor for assessment and supervised on the equipment by them. No staff on the ward had received training to supervise use of the gym equipment. The gym instructor only came a few times a week. Tony Hillis Unit and Heather Close provided walking groups and encouraged patients to participate. However, the activity coordinator at Tony Hillis Unit said they were limited to taking a maximum of three patients with them on walks as they were alone and ward staff were usually not available to accompany the group. Art, music and dance therapists worked with patients on a sessional basis at each of the units.

Staff used recognised rating scales to measure outcomes for people. These included the health of the nation outcome scores (HONOS), model of human occupation screening tool and the occupational self-assessment tool. The services used a range of other outcome measures

including the positive and negative syndrome scale, dialog+ (a self-rated satisfaction questionnaire) and CORE 10 (a brief generic measure of psychological distress). Patients completed tools on admission and every three months after that. Results were reviewed to consider the effectiveness of the treatment approach.

This service had not participated in national clinical audits in 2018. However, local audits were undertaken on the completion of care plans and patients' physical health. We found that care plan audits at Westways were not supported with a clear action plan when areas for improvement were identified. Heather Close audits on patient NEWS charts demonstrated that staff had ticked to confirm escalation had taken place when no escalation was required, this meant that the quality of the NEWS audits could not be relied upon.

Skilled staff to deliver care

The teams at Westways and Tony Hillis Unit had access to the full range of specialists required to meet the needs of patients on the ward. The ward teams at both units included skilled staff from a range of disciplines including nurses, occupational therapy, doctors and clinical psychologists. Heather Close had the same complement of staff although had not had a clinical psychologist in post for nine months. The manager informed us that they had struggled to recruit to the post and that approval had recently been given to increase the position from four sessions per week to a full-time position. Each ward could access a pharmacist. However, at Heather Close, input from a pharmacist was very limited and they only attended the unit once every two weeks.

Most staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Most staff and managers had worked at the trust for a long time across different mental health settings and had a good understanding of patients' needs. However, the practice development nurse post at Heather Close was vacant. Senior staff reported this had a detrimental effect on nurse development and skills at the unit. Managers provided new staff with an appropriate induction. Permanent staff attended the corporate induction run by the trust. Each unit had their own local induction checklist to support new staff in their role. We were informed by managers that this was in the process of being updated to incorporate some additional information, for example details of ligature points on the ward.

Managers or an appointed supervisor provided staff with supervision of their work. Records showed that staff had received regular supervision and staff told us these had taken place. However, supervision records showed that the emphasis of discussion for most registered and unregistered nursing staff was on managerial rather than clinical supervision.

Reflective practice sessions were not held consistently across all units. Staff at Westways held reflective practice sessions alternate weeks, which were facilitated by the psychologist's line manager. Reflective practice provided staff with the opportunity to consider their approaches to patient care and their own feelings. Staff at Tony Hillis Unit said they held a 'shift reflection' on most shifts to review how the shift had gone, but there were no regular facilitated reflective practice meetings. Reflective practice sessions had not taken place at Heather Close for several months. At Heather Close managers informed us that from May 2019, a psychologist from another borough was due to facilitate these meetings until a full-time psychologist was appointed.

Managers provided staff with appraisal of their work performance. Managers recorded detailed appraisal records for each member of staff appraised, although we noted that appraisals at Westways were not supported by a personal development plan for any of the files we reviewed. At 29 December 2018 the trust's appraisal rate for non-medical staff working was 95%, Westways

had the lowest appraisal rate at 86%. Appraisal records were in place for each staff file we reviewed. Appraisal rates for medical staff were not provided by the trust.

Ward name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals (as at 29 December 2018)
Heather Close	42	42	**100%**
Tony Hillis Unit (THU)	33	31	**94%**
Westways	21	18	**86%**
Core service total	**96**	**91**	**95%**

Managers ensured that staff had access to regular team meetings. Business meetings were held weekly. These meetings gave staff the opportunity to discuss any general issues relevant to the unit and were an opportunity for staff to exchange ideas.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. For example, the trust supported non-registered nursing staff to study to improve their skills and develop into the role of associate nurse practitioner.

Managers had not ensured that staff received the necessary specialist training for their roles. Despite having an autism pathway and dual diagnosis pathway, staff across the units had not received any specific training for caring for people with dual diagnosis or autism. However, we noted that, staff at Heather Close had attended an eight-day programme, Developing Complex Care (DECC) in December 2017 with one day follow-up courses in October and November 2018 attended by 45 members of the team. The programme included content around coaching skills, recovery, simulation on mental state assessments, workshops on psychosis, stigma, physical health and learning disabilities. DECC training had also been made available to all staff who worked in complex care during November 2017. There were 661 training places available across eight days, although attendance on each day was variable. The trust did not provide details of attendance by staff who worked Tony Hillis Unit or Westways and there has been some staff turnover since this time, including a new manager at Westways.

Managers dealt with poor staff performance promptly and effectively. Managers took appropriate action and followed the trust's disciplinary policy as required.

Multidisciplinary and interagency team work

Staff held regular and effective multidisciplinary meetings. The units held weekly multidisciplinary meetings that staff from all disciplines attended. Staff worked together effectively to review each patient every week and manage their progress as well as their discharge or transfer. All staff attending these meetings were able to contribute their views on patients' progress.

The ward teams had effective handovers between changes in nursing shift and we observed these taking place. The lead nurse from the out-going shift led the handover and briefed all on-coming staff about each patient on the ward as well as any incidents which had occurred. Staff provided handovers to other units when patients were transferred from the ward.

The ward teams had effective working relationships with teams outside the organisation. Staff regularly liaised with patients' community care coordinators, and other wards across the hospital.

Staff also communicated regularly with the clinical commissioning group who paid for each patient's care, social services as well as patients' GPs, legal advisors and other organisations that provided support to the patients.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

As of 31 December 2018, 90% of staff in this core service had completed mandatory training in mental health law. Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles. The trust stated that this training was mandatory for all inpatient staff and renewed three years.

Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who their MHA administrators were. Staff could access support and advice from the MHA office during office hours. Outside these times, legal advice was available by telephone.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local MHA policies and procedures and to the Code of Practice. These documents were stored on the trust's intranet site for all staff. Policies were regularly reviewed to ensure they considered the latest guidance as well as any local changes

Patients had easy access to information about independent mental health advocacy. The service provided all detained patients with written information about their rights under the MHA. This information included the contact details of the advocacy service. Wards also displayed contact details of advocacy services on notice boards. At Westways and Tony Hillis Unit advocates visited the wards each week and could be contacted by patients by telephone on request. The advocacy service for Heather Close had recently been taken over by a new provider, patients could request an advocate to attend the unit and patient records showed that this had been facilitated. Most of the patients we spoke with were aware of their right to see the IMHA.

At the last inspection in September 2015, we found that staff at Heather Close and Tony Hillis Unit did not understand aspects of the MHA for the patients under their care. During this inspection, we found that staff did understand the MHA relevant to the patients under their care. Staff explained to patients their rights under the MHA in a way that they could understand, although this was not done or recorded consistently. Most of the patients we spoke with knew about their rights. However, there was some confusion amongst staff regarding the frequency of staff explaining patients' rights to them. Staff did not consistently remind patients of their rights or document that they had done so in accordance with trust policy. Trust policy stated that staff should explain patients' rights on admission, when the patient's section changed as well as other trigger points, for example if the patient moved wards. Staff on Tony Hillis Unit gave different accounts when describing how staff explained to patients their rights under the MHA. One member of staff said that they explained rights to patients every week or monthly depending on their needs, whereas another said this was always done every month. Records showed that patients at Tony Hillis Unit had their rights explained to them monthly until November 2018. Since that time the recording of rights discussions in patients' notes had become more sporadic and did not coincide with significant events, such as a patients' admission to the ward or the renewal of detention under section 3.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted. Doctors granted patients leave as part of therapeutic intervention. Clinicians had clearly recorded the start and end date of patients leave and recorded

an overnight address where this was applicable. Staff undertook risk assessments prior to patients taking their leave to ensure they did not present a risk at that time.

Informal patients could leave the units at will and they knew that. At the time of inspection, patients at most of the units were admitted under a section of the Mental Health Act. At Westways there were six informal patients and at Heather Close there were five. Staff reminded patients that they could leave at will and there were also signs placed on the door as reminders.

Patients were not always administered medication in accordance with consent to treatment under the MHA. At Tony Hillis Unit, we found that the prescription chart for one patient had several certificates to confirm the patient had consented to treatment as well as certificates authorising their treatment, which were signed by an independent doctor. This made it difficult for staff to determine which certificate currently authorised the treatment being given to the patient. At Heather Close, we found certificates required by section 58 of the MHA to authorise treatment with medication completed either by the responsible clinician to confirm that the patient could give valid consent or by the second opinion appointed doctor where the patient lacked mental capacity or was refusing specific medication. However, we found that the medication on the legal authorisation certificates differed from the prescribed medication in eight records we reviewed. This meant that patients were being prescribed medication, which was not in accordance with either the patient's consent or the authorisation given by their psychiatrist and/or second opinion doctor.

Staff stored copies of patients' detention papers and associated records correctly and so that they were available to all staff that needed access to them. Staff at the MHA office stored original documents in a locked cabinet.

Staff undertook regular audits of the MHA to ensure relevant paperwork was being completed. However, we noted that whilst the audits reported on whether consent to treatment/ authorisation to treatment was listed in the audit, the audit documentation did not include a section to state whether it agreed to the medication being prescribed. Staff on Tony Hillis Unit had started a quality improvement project on the ward aimed at improving the completion of MHA paperwork and the timely completion of reports for tribunals. This had involved the development of a specific template for recording MHA information and a weekly audit.

Good practice in applying the Mental Capacity Act

As of 5 March 2019, 82% of staff had completed training in the Mental Capacity Act (MCA). The trust stated that this training is mandatory for all services for inpatient and all community staff and renewed every three years.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. The provider had a policy on the MCA, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it on the intranet. Most staff understood the MCA and the five statutory principles. However, on Heather Close, there was one patient who had a deprivation of liberty safeguards application made in the last 12 months. Staff understood that the patient was not permitted to leave the building because a deprivation of liberty safeguards was in place but some did not understand why it was in place.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent. The treating clinician's assessments of patients' capacity to consent to treatment was recorded on all but one of the patient's records we reviewed. This was revisited regularly in ward review meetings.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. One patient's care record showed that staff were unsure that the patient was making an informed decision with regards to retaining possession of their flat. Staff recorded they had considered whether the patient required a best interest decision to be made. Best interest decisions had also been made for a patient who lived with a terminal illness around his care and treatment for his physical health diagnosis.

Staff audited the application of the MCA and acted on any learning that resulted from it.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it. Staff demonstrated a caring, respectful and compassionate attitude towards patients when interacting with them. They showed that they understood the needs of patients. The ward teams were person-centred in their approach to care. Staff prioritised patients' needs above other tasks. Patients told us that staff were caring and helpful.

Staff supported patients to understand and manage their care, treatment or condition. Staff and patients told us how some patients had progressed since being at the service through the support and care of the staff and the activities that were taking place.

Staff knew patients well. They were familiar with their histories and recognised changes in mood and behaviour. They worked patiently with people to build trust and improve engagement. Patients said staff treated them well and behaved appropriately towards them.

Patients reported that staff always knocked and waited before entering their room and respected their privacy and dignity.

Staff maintained the confidentiality of information about patients. Handovers, multidisciplinary meetings and ward rounds all took place in a designated room to ensure discussions about patients could not be overheard.

The patient led assessments of the care environment (PLACE) survey was carried out in 2018. The scores for privacy, dignity and wellbeing for Heather Close was 79.6%, which was much lower than the England average of 91%. Scores for the other locations were combined with other wards on the same site therefore may not be reflective of that unit.

Site name	Core service(s) provided	Privacy, dignity and wellbeing
LAMBETH HOSPITAL	Acute wards for adults of working age and psychiatric intensive care units Long stay/Rehabilitation mental health wards for working age adults	87.6%
BETHLEM ROYAL HOSPITAL	Acute wards for adults of working age and psychiatric intensive care units Long stay/Rehabilitation mental health wards for working age adults	92.1%
1-5 HEATHER CLOSE	Long stay/Rehabilitation mental health wards for working age adults	79.6%
Trust overall		**88.7%**

Site name	Core service(s) provided	Privacy, dignity and wellbeing
England average (mental health and learning disabilities)		**91%**

Involvement in care

Involvement of patients

Staff used the admission process to inform and orient patients to the ward and to the service. Patients received an information booklet on admission that included information about the ward and their rights. Staff also took the time to speak with patients who were new to the ward about the activities available and what their treatment would involve.

Staff involved patients in care planning and risk assessment at Tony Hillis Unit as well as Westways, although this was not always recorded at Heather Close. There was evidence at Westways that patients were involved in development of their care plans and risk assessments and that they had been provided with a copy of their care plans. Tony Hillis showed evidence of patient involvement in care plans, although not that patients had received a copy.

Staff communicated with patients so that they understood their care and treatment. Staff held regular individual sessions with patients. Staff also involved patients in their Care Programme Approach (CPA) meetings. Patients at Heather Close were encouraged to chair their own CPA meeting. Staff and patients had co-produced the questions they would ask to facilitate the meeting. Seventy percent of patients said they would like to chair their CPA meeting again having experienced it. Westways were at the early stages of working with patients to engage more actively in their CPA meeting. Patients were given a form to complete prior to their meeting about things they would like to discuss. Staff supported them to complete the form and patients found this helpful.

Staff involved patients, when appropriate, in decisions about the service. Patients met regularly with staff in community meetings. Minutes of the meeting were taken. Staff followed up issues raised by patients and fed back on progress at the next meeting. A lack of variety of meals regularly featured as a discussion point and patients were reminded that their concerns had been shared with the contractor.

Staff regularly asked patients to provide feedback about the service. Each unit asked patients to complete a feedback questionnaire every month. The trust used the patient experience data intelligence centre as a system to gather information about the experiences of patients and carers. Staff used the feedback to help them to make improvements. Staff used ‘you said, we did’ boards on the units to give feedback to patients about the action that had been taken to address concerns they had raised.

Staff ensured that patients could access an independent advocate. A patient advocate visited Westways and Tony Hillis Unit every week and contact details of the advocacy services were displayed on the notice board of each unit.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff kept in contact with family members and carers with patients’ consent. At Tony Hillis Unit, staff contacted carers/relatives every six weeks. At Heather Close, a support worker led on the work with carers and was the main point of contact for carers/relatives. The consultant psychiatrist said they were aiming to improve

the involvement of carers overall. At Westways the clinical psychologist worked closely with a member of the nursing team to boost carer and family involvement in patient care and treatment. The clinical psychologist was in the process of setting up a carers forum and a survey had been sent out to carers to engage with them about this development There were no specific carer groups offered at Tony Hillis Unit or Heather Close.

Staff enabled families and carers to give feedback on the service they received. Staff invited families and carers to attend meetings to review patients' individual progress and support the patient. Families could provide feedback to staff directly at these meetings. Patient records showed communications with families including invitations to attend review meeting, if the patient consented. There were comment cards available on each of the units for patients and their families/carers to provide feedback. Heather Close used the trust-wide specific carer experience survey, which enabled carers to give feedback on how they have experienced the service. On Tony Hillis Unit, the carer experience survey was trialled, however responses were low for completion on the ward. Staff instead posted a paper survey to carers' addresses, with a pre-paid return envelope to encourage feedback. The ward has also completed a carers' involvement audit pilot with a view to conduct monthly audits.

Is the service responsive?

Access and discharge

Bed management

The service reported no out-of-area placements between the period 1 February to 31 December 2018.

Beds were available when needed for patients living in the catchment area. Each unit served patients from different catchment areas. Westways only accepted patients who lived in Croydon. Tony Hillis Unit had six beds allocated to patients from the National Psychosis Unit also provided by the trust. These patients came from all over England.

There was a waiting list of patients for admission. Staff from the units visited patients to assess whether they were suitable for a rehabilitation service prior to admission. Waiting lists were low for each of the units, although due to the length of stay of patients, the average wait for a bed varied between from approximately six weeks to nine months. Westways had three patients on their waiting list, Tony Hillis Unit had five people waiting from the National Psychosis Unit, although this was under negotiation, and three people waiting from within the SLP. Heather Close had two patients on the waiting list. Each site had a weekly beds meeting where all patients were discussed, updates were also sent to the commissioners on current inpatients and availability of beds. Referrals meetings were held on a weekly basis, new referrals were considered as well as positive moves out.

There was always a bed available when patients returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. Staff told us about patient who had been moved and another who was being assessed for referral on to a new service because the units were no longer able to meet their needs. Westways reported one patient who had become increasingly unstable, action was taken to ensure this patient was safely transferred back to an acute ward.

The average length of stay for the service ranged from between 75 to 685 days between the period 1 February 2018 to 31 December 2018.

Ward name	Average length of stay range (1 February 2018 – 31 December 2018)	
1 Heather Close	2	357
5 Heather Close	28	801
Rehabilitation Ward – Westways	161	711
Tony Hillis Unit – CBU	110	872

Each unit aimed for a slightly different length of stay but this ranged from between six to 12 months across each of the different units. Some patients had been on the units for many years. Heather Close aimed for a length of stay of seven months although there were three or four patients who had been at the service for many years. On each of the wards, most patients came from acute inpatient wards with a small number admitted from the National Psychosis Unit and forensic wards.

This service reported no readmissions within 28 days between 1 February 2018 to 31 December 2018.

When patients were moved or discharged, this happened at an appropriate time of day. Discharges out into the community, including to supported living as well as transfers to other inpatient wards, always followed a graduated approach. The patient would be prescribed leave to initially spend several hours at their new home or placement followed by an overnight stay, then a weekend stay, until the patient and staff felt confident that the patient was ready to be moved or discharged from the service.

Discharge and transfers of care

Between 1 February 2018 to 31 December 2018 there were 13 discharges within this service. This was an improvement from the previous inspection in September 2015, when 57 delayed discharges were reported.

Patients' discharge planning was not formally documented in their care plans until patients were close to being discharged from the service. Managers and staff told us that where possible they planned for patients' discharge from the point the patient was admitted to the service. Managers informed us that on admission a patient was assessed and their potential discharge pathway was considered. However, records showed that staff did not record in patients' notes what their discharge plans were until shortly before their intended discharge. There were no clear goals set for patients to help them achieve recovery goals, and eventual discharge. One patient at the Tony Hillis Unit told us that they did not know what plans had been made for their discharge and we were unable to find evidence of work on recovery goals with a view to discharge recorded in the care plans we examined.

Although patient records did not contain clear goals or details of discharge planning, staff made positive efforts to facilitate discharge and we saw some good examples of this at Westways and Heather Close.

Westways had adopted the recovery star model as a means to support patients to manage their mental health on their pathway to recovery. The recovery star was being used for eight out of 16 patients. There were 10 key areas covered by the model, which included focus on living skills, social networks, work and relationships. This was underpinned by a five-stage journey of change. This was a new initiative for the unit and not all patients were ready to engage with it.

At Heather Close, the consultant psychiatrist held ‘red2green’ meetings on a weekly basis with the multidisciplinary team. The consultant said this involved discussing and colour coding patients’ progress towards discharge. He said this had made a difference and increased the rate of discharge from the ward.

The consultant psychiatrist was planning to attend a funding panel with the local authority where future placements for three patients were due to be discussed in May 2019. Three patients had been discharged in March and three in April.

Managers attended weekly bed meetings. At these meetings every patient was discussed and this included discussing patients who were ready to be discharged or transferred and whether anything additional was required to facilitate the discharge, actions were agreed and assigned to the most appropriate individual.

Discharge was delayed for a range of reasons. Each of the units aimed for a length of stay of six to 12 months although there were patients on each ward who had been at the service for many years. Managers informed us that it was more realistic for new admissions to be discharged within that time frame because historically, some of the existing patients had been inpatients for many years. Managers also reported that it was sometimes difficult to find placements for patients who had a forensic history. The service was dependent on the Ministry of Justice completing the required paperwork and this could lead to delays in discharge. There were plans being developed with the South London Partnership to reconfigure the rehabilitation model and address the issue of long lengths of stay on these wards.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. On Westways and Tony Hillis Unit, staff could not close viewing panels in the bedroom doors but there were curtains in place to help maintain privacy and dignity for patients.

Patients could personalise bedrooms and we saw that some patients displayed photos and personal belongings. One patient had several posters of his favourite popstar displayed in his room.

Patients had somewhere secure to store their possessions. Patients on each of the units had a locker on the ward where they could store personal items safely.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. The wards varied in the range of rooms and equipment they had to support treatment and care. At the last inspection in September 2015, we found that Heather Close had very limited therapy space. The room used for clinical psychology at Heather Close also doubled as a storage area and did not have sound proofing. During this inspection, we found that Heather Close had decommissioned unit 3, a six bedded unit, and plans were being developed to convert the entire unit into therapy space for patients. The Tony Hillis Unit had a gym situated next to the lounge, although this could only be accessed when the gym instructor was present. There were activities of daily living kitchens on each unit. Patients required an assessment before they could use this.

There were quiet areas on each ward and a room off the unit where patients could meet visitors. Patients were able to make telephone calls in private. At the last inspection in September 2015, we found that not all patients had access to use a phone in private if they wanted to. During this inspection, we found that the patient telephone on Tony Hillis Unit had recently been damaged beyond repair. Patients could use their own mobile phones or the ward office cordless phone to

make calls. Patients at the other two units had access to a cordless phone provided by the service or they could use their personal mobile phones.

Patients had access to outside space. Westways did not have a garden attached to the building but there were plenty of open gardens within the hospital grounds and most patients either had prescribed leave or were informal. Tony Hillis Unit had two enclosed garden areas and Heather Close had one garden. Patients were able to go out either accompanied by staff or unaccompanied. Access to the garden areas at Tony Hillis Unit was restricted after a certain time, the manager informed us the door was locked at midnight and staff informed us that access to the garden was restricted after 8pm.

Different food options were available for patients although this did not always meet the cultural needs of patients. Patients reported mixed satisfaction with the quality of the food provided. Staff said there was a choice of meals and some options for those with specific dietary needs such as vegetarians and those with religious needs. At Heather Close staff said that patients could choose their meal option on the day, when meals arrived. Patients at Tony Hillis Unit ordered their food two weeks in advance, this caused problems for the patients who may not wish to eat their preferred option from two weeks prior. Discussion around food regularly featured at the patient community meetings. The consultant psychiatrist at Heather Close said that the team had approached the meal providers regarding improvement needed in terms of the quality and variety of meals provided. A new menu had been started in April 2019. The trust informed us that they were liaising with the contractor who provided the food service to make improvements to the ordering arrangements as well as the quality of the food provided.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for ward food was below the England average of 92.2% at each of the trust locations. Data was reported on by location which included the score for all ward types at that location. Bethlem Royal Hospital where Westways was located scored 92%, Lambeth Hospital where Tony Hillis Unit was located scored 88.2% and 1-5 Heather Close scored 83.4%.

Site name	Core service(s) provided	Ward food
LAMBETH HOSPITAL	Acute wards for adults of working age and psychiatric intensive care units Long stay/Rehabilitation mental health wards for working age adults	88.2%
BETHLEM ROYAL HOSPITAL	Acute wards for adults of working age and psychiatric intensive care units Long stay/Rehabilitation mental health wards for working age adults	92%
1-5 HEATHER CLOSE	Long stay/Rehabilitation mental health wards for working age adults	83.4%
Trust overall		**89%**
England average (mental health and learning disabilities)		**92.2%**

Patients on all units could make hot drinks and snacks throughout the day and night.

At Heather Close, where the consultant described having a pathway for patients with autism, there were periods of time that were designated quiet times in one of the communal areas and patients who preferred to could have their meals in a quiet area.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. Each of the units supported patients to attend college and paid or voluntary work where possible. Westways had one patient who was due to start voluntary work at the hospital shop with a view to them progressing to work in a charity shop in the local area once they felt confident to do so. Another patient had been supported to attend the recovery college in the past. Heather Close also supported patients to achieve individual goals. One patient carrying out voluntary work and another was attending IT college. The band 6 OT at Heather Close had specialist training in autism and was providing intensive support for one patient to develop their vocational skills. Tony Hillis staff were supporting two patients to work in a local café one day per week and one patient did voluntary work daily with the local hospital group. Another patient wanted to re-take their A levels and was supported to attend the library every day.

Staff supported patients to participate in activities outside of the unit. The activity coordinators took patients outside the unit. Activity coordinators worked seven days a week on Tony Hillis Unit and supported patients to take part in activities both inside and outside the unit. Patients were encouraged to access existing groups in the community, such as cafes, the local library and activity groups. For example, some patients attended a 'wheels for well-being' group at a local velodrome and a music group in Brixton.

Meeting the needs of all people who use the service

Two of the units were accessible to patients with disabilities. At Heather Close there were bedrooms on the ground floor, two of the bedrooms had been adapted to accommodate patients with some degree of physical disabilities. The unit had use of a hoist if required. There was a lift to the upper floor, although this was not used out of hours due to a lack of emergency support at those times. Tony Hillis Unit was on the ground floor and able to accommodate patients with some degree of physical disability. There was no disabled access on Westways, patients would be referred on to other units if they required specific support with physical enablement.

Information was available in different languages and braille on request. Two of two staff we spoke with were not aware of the requirements of the accessible information standard.

Heather Close had devised communication passports for patients with learning disabilities. Communication passports allowed the patient to share information with external health professionals as well as staff on the ward. The communication passport for one patient with a learning disability included information about their likes and dislikes as well as things which made them anxious. The passport was in an easy to read format and supported by pictures.

Managers ensured that staff and patients had easy access to interpreters and/or signers. Staff said they used interpreters to communicate with patients who did not speak English well especially when they had important decisions to take.

Patients had a choice of food to meet their dietary requirements of religious and some ethnic groups although some patients told us they would like an option of Jamaican meals from time to time.

Staff ensured that patients had access to appropriate spiritual support. Staff supported people to attend places of worship and spiritual significance if the patient wished. Patient information on the wards indicated that the trust spiritual/pastoral team could visit and there was a multi-faith room in Lambeth Hospital which patients at Tony Hillis Unit could use. The Bethlem Royal Hospital also had a multi-faith room which patients at Westways could access. Patients at Heather Close were

supported to access places of worship in the community if they desired; staff at Tony Hillis Unit supported one patient to attend the local mosque every Friday.

Staff had some understanding of individual needs of patients, including their personal, cultural, social and religious needs. Staff said they had received some training in equality and diversity but not any specific training in how to meet the needs of LGBT+ patients. Staff had not considered the need to make the ward welcoming for patients with protected characteristics, although we noted that Westways displayed a rainbow banner at each end of the ward. The welcome packs for patients at each unit made no references to the needs of specific groups. The activity coordinator had led the celebration of black history month. Heather Close staff ran a women's group for female patients on Saturdays and provided quiet areas and times on the unit to support patients with autism.

Listening to and learning from concerns and complaints

During the period 1 January 2018 to 31 December 2018, Heather Close and Tony Hillis Unit received three complaints each. Westways had not received any formal complaints. One of the complaints at Heather Close was withdrawn, the outcome of another was unknown and one was partially upheld. At Tony Hillis Unit, one complaint was upheld, another partially and one not upheld. Westways did not receive any complaints about the service.

Ward name	Total Complaints	Fully upheld	Partially upheld	Not upheld	Unknown	Withdrawn
Heather Close	3		1		1	1
Tony Hillis Unit (THU)	3	1	1	1		

Patients knew how to complain or raise concerns. At the last inspection in September 2015, not all patients were aware of how to make complaints. During this inspection, we found that there were suggestions boxes located in communal areas on the wards where patients could post their comments, suggestions and complaints. Information on how to make a complaint was available on the wards. At Heather Close, the manager held a complaints surgery very Wednesday morning. The surgery allowed patients to meet with the manager and discuss any concerns, complaints or give feedback about their care.

Staff knew how to handle complaints. The trust had a complaints policy and staff knew how to access this. Informal complaints were dealt with as they arose. If patients wanted to make a formal complaint staff supported them to do this. The complaint was logged locally as well as with the central complaints team. The complaints department assigned the complaint for investigation to the most appropriate person.

When patients complained or raised concerns, they received feedback. When a formal complaint was made which required investigation, patients received communication from the trust acknowledging their complaint. The investigating office provided a written response which was sent to the complainant. Complainants were also invited to meet with the manager to discuss their concerns and records showed that this happened.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. We were told that complaints were discussed at handover meetings as well as the team meetings.

Is the service well-led?

Leadership

Leaders had the experience to manage the units safely. Two of the ward managers had been in post for more than seven years, one manager had been in post for one year and had extensive experienced working in other units across the trust including as a manager. However, there was no clear strategy to ensure each of the service was focussed on providing a strong rehabilitation service.

Leaders understood the services they managed, although more work was needed to ensure the service was recovery orientated for all patients. Managers were aware of where staffing shortages were and the impact this had on both staff and patients, efforts were being made to recruit more staff. They understood what the local risks were and what quality assurance measures were in place. Ward managers knew the names of all the patients and had a good understanding of each patient's individual day to day needs. Managers recognised that a coordinated approach was needed to ensure a high-quality service was provided to support patients to become well and learn to live independently and that more work was needed to ensure that this happened.

Leaders were visible in the service and approachable for patients and staff. Senior managers were visible on the wards. Staff were positive about their input. Staff reported the ward managers at Heather Close and Westways regularly met with patients.

Leadership development opportunities were available, including opportunities for staff below ward manager level. Ward managers had completed various management courses during their time in post. Leadership training was available for team leaders. Ward managers also involved team members in managerial development through involvement in investigating incidents, complaints as well as leading on audits.

Vision and strategy

Managers knew and understood the provider's vision and values and how they were applied in the work of their team. Managers understood that the vision was aimed to improve the lives of people and the community they serve. Managers understood the trust vision was underpinned by clearly defined values.

Managers reported there was no overarching strategy for rehabilitation services in the trust. The trust informed us that this is being addressed through the SLP with an overall aim for every patient to be placed in the most appropriate and least restrictive setting, closer to home as possible with an outcomes-based care plan. They informed us that a workstream had been established to define an integrated complex care pathway and identify models of care to optimise the inpatient rehabilitation service. There was no defined timeline of when this would be achieved. This meant that whilst managers and staff worked hard to support patients to return to the community, there was no clearly defined structure or pathway to follow and achieve this. There was evidence of some good rehabilitation orientated work going on at each of the units. However, it was not structured, and some patients were not supported to achieve basic levels of skill prior to discharge, for example better medicines management or self-medication. Staff were unable to articulate a clear model or approach to rehabilitation.

Ward managers were able to explain how they worked to deliver high quality care within the budgets available and how they supported staff to do this. Ward managers were responsible for working within budget and ensuring that staff who worked on the ward provided good care to patients.

Culture

Most staff felt respected, supported and valued. Staff had not reported any cases of staff bullying or harassment cases on the wards and told us that they felt supported by their colleagues.

Staff felt able to raise concerns and were sure they would be taken seriously.

Staff knew how to use the whistle blowing process and a copy of this was available on the trust intranet.

On the whole teams worked well together and where there were difficulties managers dealt with them appropriately. However, at the last inspection we found that there was a poor staff culture at Heather Close. During this inspection we found that some staff at Heather Close expressed concerns that a few registered nurses remained upstairs in the office during the majority of the shift and telephoned downstairs to get an update from non-registered staff about patients. Some staff at Heather Close also raised that they were not allowed to take a single day of annual leave if they wished to and that they had to book one week off at a time. Staff said they would have to make a special case for a single day of annual leave, which was contrary to trust policy. Other staff said there was a lack of flexibility in respect of alternative shift patterns.

Staff appraisals included conversations about career development and how it could be supported. We reviewed a sample of staff appraisals during our inspection. Managers discussed career pathways with staff and how they could support their development.

Staff spoke positively about opportunities for professional development. There were development opportunities available for both registered and unregistered staff. The wards accepted student placements and encouraged students to join the trust once they had completed their course.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. Ward managers and staff members came from diverse backgrounds. All staff were aware of the opportunities within the trust for them to advance their career.

The service's staff sickness and absence were similar to the average for the provider. Two of the units had a higher than average sickness rate, Tony Hillis Unit was the highest at 9%; Heather Close 6.1% and Westways the lowest at 4.7%. Ward managers supported staff who had frequent or long-term sickness following the trust's sickness management process.

Staff were aware that they could access support for their own physical and emotional health needs through the trust's occupational health service. Managers informed us that they referred employees to the service in accordance with trust policy, staff could also make self-referrals.

The provider recognised staff success within the service. For example, Tony Hillis Unit had recently been nominated for the best ward award in SLAM, the unit came second to Spring Ward on the forensic unit. Two of the staff who set up a quality improvement programme to support patients with substance misuse had also been nominated for and won an award for this quality improvement project. Heather Close had also won an award for implementing 'red2green' and reducing the length of stay.

Governance

Governance arrangements were in place within each unit that supported the delivery of the service.

There was a clear framework of what must be discussed at a ward and team level to ensure that essential information was discussed, although this was still being embedded. Weekly business

meetings were held where teams met to discuss the day to day running of their unit. Monthly governance meetings were rolled out by the trust to the rehabilitation units in January 2019, all staff who worked on the units were invited to attend. The trust had agreed standing agenda items such as learning from incidents, complaints, safeguarding and audits. However, records showed that the meetings were not well embedded and that discussion around these topics varied and not working as intended. Three meetings had taken place at each unit. Tony Hillis Unit were only able to provide minutes of the second meeting, at this meeting staff discussed what needed to be covered under each agenda item. At Heather Close, minutes for each of the three meetings were provided. Discussion under each agenda item focussed on quantity rather than quality, for example, how many incidents had been reported or to remind staff that supervisions must take place. There was little or no discussion evident in the minutes around learning from incidents or complaints or how the quality of staff supervision could be used to improve patient care. Governance minutes for Westways were in note format, it was clear from the notes that some discussion around incidents had taken place on the unit as well as audits, but written records were not sufficiently detailed to understand exactly what had been discussed. This meant that when minutes were circulated to staff unable to attend the meetings, they lacked sufficient detail to convey what had been discussed or what actions had been agreed.

Senior staff at each of the units attended regular quality meetings that included managers from across the services within their borough directorate. Modern matrons from across the trust met monthly to share ideas.

Staff participated in local audits. Examples of audits included care plan audits, medication audits as well infection control audits. The audits supported ward managers and team leaders to identify areas of improvement, although audits had not always been completed thoroughly and accurately and were not always supported by action plans. For example, at Heather Close, the modern matron undertook a monthly audit of the ward, but this was not always effective in identifying concerns or shortfalls, for example the dirty fridge in the clinic room. At Westways, care plan audits identified shortcomings with some of the care plans yet there was no evidence as to the action undertaken to address these.

Management of risk, issues and performance

The ward manager on each ward maintained a risk register. Staff had access to the risk register at ward and directorate level. Staff at ward level escalated concerns to the manager; the manager assessed risks for their likelihood and impact and added risks to the register if they met agreed criteria. The risks identified on the risk register matched concerns discussed with staff during the inspection.

The service had plans for emergencies; this included contingency arrangements for adverse events. Ward managers knew how to access the plans and would refer to these in the event of an emergency. The continuity plans included basic instructions for staff to follow in the event of a major incident, or disruption to the wards due to loss of utilities and inadequate staff cover. Contact details for staff had also been included in the plans.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff. The ward managers were required to collate and submit data to various central teams, for example human resources. Managers used data to have oversight of their ward.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked. The online patient record system was easy to use but internet access was very slow. This meant that staff spent more time than necessary updating and reviewing patient records. This was frustrating for staff and detracted from providing patient care.

Information governance systems included confidentiality of patient records. Patient records were in an electronic format, where paper copies were used, for example recording a patient's NEWS score these were scanned on to the system. Staff could only access electronic patient records by entering a personal user name and password.

Information governance training was included within the trust's mandatory training modules. The training informed staff on how to maintain confidentiality. Staff compliance in this training was 89% across the service.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. For example, team managers could access an electronic system that provided data on the number of incidents. Managers also received monthly data on the number staff who had attended mandatory training and the rate of staff sickness. Performance information about patients' length of stay and discharge rate was also received.

Information was in an accessible format, and was timely, accurate and identified areas for improvement. Information for ward managers was easy to understand and updated every month.

Staff made notifications to external bodies as needed. For example, one serious incident had been reported to the commissioner. The service made safeguarding referrals to the local authority safeguarding team when they were concerned about the possible abuse of patients.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. Staff kept patients up to date by displaying information on notice boards as well as discussion any relevant matters during their one to ones. Staff received regular bulletins and newsletters from the trust that kept them informed of developments and incidents in other parts of the trust.

Patients had opportunities to give feedback on the service they received in a manner that reflected their individual needs. There was minimal opportunity for carers to provide feedback. One of the trust's goals was to work with patients and their support networks to realise their potential. Patient community meeting minutes showed that patients were given the opportunity to provide feedback about the service.

Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements. We saw 'you said, we did' boards which demonstrated that staff had reacted to feedback from patients and made improvements when they could.

Learning, continuous improvement and innovation

Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes. The units had introduced innovative and successful approaches to care and treatment including running a behavioural treatment of substance misuse group at Tony Hillis Unit, patients chairing their own CPA meetings and the introduction of health passports and communication passports for patients with an identified learning disability at Heather Close.

Patients used the passports to share information about themselves with staff in other clinical settings who may not be familiar with them as an individual such as GPs or consultants from a general hospital. Information about the individual was included in a easy to read format and accompanied by pictures. For example, the communication passport for one patient with a learning disability included information about their likes and dislikes as well as things which made them anxious.

Staff used quality improvement methods and knew how to apply them. All units were successfully using a quality improvement approach to bring about change and improvements in care. For example, Heather Close had adopted the red2green initiative to increase the focus on patient discharge. Outcome measures, such as length of stay and numbers of discharges, were recorded and analysed to determine whether a shift or change had been achieved. Staff on Westways had adopted the recovery star to help provide focus on patient improvement by supporting patients manage their mental health on their pathway to recovery. The star was being used for eight patients.

Wards participated in accreditation schemes relevant to the service and learned from them. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. Tony Hillis Unit was AIMS accredited through the Royal College of Psychiatrists. Westways and Heather Close had both completed stage 1 (peer review) of the accreditation process. However, Heather Close was unable to achieve accreditation as there was insufficient pharmacist input into the service and no clinical psychologist in post for the last nine months.

Community-based mental health services for adults of working age

Facts and data about this service

South London and Maudsley Foundation Trust provides a range of community based mental health teams for adults of working age living in the London boroughs of Croydon, Lambeth, Lewisham and Southwark. These teams offer specialist assessment, care and treatment for adult patients (age 18 - 64) whose mental health needs cannot be met by their GP. The trust has an operations directorate for each borough to manage both community and inpatient services. Each community based mental health team links with a group of GP practices and statutory and voluntary agencies in their local area.

The teams mainly receive referrals from inpatient mental health wards, accident and emergency departments and GPs. The teams aim to work in partnership with patients to promote recovery and social inclusion. Staff plan and deliver care and treatment for a limited time-period and refer patients to the care of their GP when their mental health has improved.

This was a comprehensive inspection which was announced two working days in advance to ensure that everyone we needed to talk to was available.

We inspected these services:

- Croydon assessment and liaison team
- Croydon early intervention team
- Croydon promoting recovery team - Thornton Heath, Woodside and Shirley
- Croydon promoting recovery team - Mayday network
- Lambeth assessment and liaison team
- Lambeth early intervention team
- Lambeth promoting recovery team - north
- Lambeth promoting recovery team - south east
- Lewisham assessment and liaison team
- Lewisham early intervention team
- Lewisham promoting recovery neighbourhood 1 team
- Lewisham promoting recovery neighbourhood 2 team
- Southwark assessment and liaison team - south
- Southwark early intervention team
- Southwark promoting recovery team - north west

Is the service safe?

Safe and clean environment

Community based mental health teams were based in suitable premises which were clean and well-maintained. At all team sites, staff carried out health and safety checks of the premises and identified any risks for action. Staff told us that maintenance issues were promptly addressed. Records showed that the premises had been cleaned as planned.

Reception staff told us they felt safe. Staff controlled entry to the premises. Interview rooms were fitted with alarms that staff could use in an emergency. Staff made checks to ensure the alarms were working and practised how to respond to an alarm.

Reception areas, interview rooms, clinic rooms and other areas of the premises were clean and well-maintained. Staff followed the trust's infection control procedures.

Equipment for monitoring the health of patients and equipment for use in an emergency was clean and fit for purpose. Staff made checks of such equipment at the correct intervals.

Appropriate fire safety equipment was available and fire drills had taken place.

Safe staffing

Community mental health teams had enough staff with the right qualifications, skills, training and experience to keep people safe and to provide the right care and treatment. Where there were unfilled vacancies for registered nurses and other staff, such as occupational therapists and psychiatrists, vacancies were filled by agency staff. The trust, in common with other trusts in London had difficulty in recruiting permanent registered nurses. The vacancy rate across the service was 17% for registered nurses at 31 December 2018.

Some agency registered nurse and care coordinator staff had been in post for several years. However, in some teams there was a high turnover of agency staff. Managers told us that agency staff were only required to give two weeks' notice before leaving their post and this made it difficult to organise the safe handover of their caseloads. Additionally, new staff, whether agency or permanent, had a period of induction and protected time whilst they built up their caseload. Consequently, the caseload of other team members increased.

At our previous inspection in July 2017, we found that care coordinators in the early intervention teams had caseloads which were much higher than the 15 recommended in national guidance. At this inspection, most staff the early intervention teams told us that they felt they could manage their workload. Since our previous inspection, the trust has continued to act to ensure staff had manageable caseloads. In all the teams, managers had good oversight of staff caseloads and were supporting those staff with a larger than average caseload to reduce it. The average caseload size in all the early intervention teams continued to exceed 15. However, staff felt that they could manage their caseload and provide individual patients with a range of appropriate support. For example, in the early intervention team in Croydon, full-time care coordinators had an individual caseload of around 23 patients. In the other teams across all the boroughs, caseloads generally did not exceed 35 which was the maximum set by the trust.

Managers provided clinical supervision for staff which assisted them to manage their caseloads. Additionally, there were scheduled multidisciplinary team meetings discussion to focus on complex and risky cases and to ensure patients were discharged from the teams when appropriate. Teams discussed general caseload issues at team business meetings and looked at ways of making improvements. For example, the Lambeth assessment and liaison team changed the operation of the team duty system in January 2019 with the aim of ensuring that all team members had a manageable caseload.

The sickness rate across the service was 3.6% between 31 January 2018 and 31 December 2018. The most recent month's data (31 December 2018) showed a sickness rate of 2.7%.

Teams operated a duty service to ensure patients received a safe service. Care co-ordinators covered duty on rotation, so that there was always a member of staff available to respond to any urgent concerns. During the inspection, we observed that teams planned for duty staff to cover for sick or absent colleagues. Team managers and staff were flexible and supported the duty worker when necessary with urgent home visits. Duty staff said they were easily able to access advice or input from a psychiatrist.

The compliance for mandatory and statutory training courses at 31 December 2018 was 83% across the service. Where training was incomplete, managers reminded staff during supervision and the trust prompted them via email alerts to complete training.

Key:

Below CQC 75%	Met trust target ✓	Not met trust target ✗	Higher ↑	No change →	Lower ↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
ASCOM	3	3	100%	✓	N/A
MEWS	3	3	100%	✓	↑
Safeguarding Children Level 3	2	2	100%	✓	↑
Moving and Handling - Loads - Group 1	1	1	100%	✓	N/A
Basic Life Support - Group 1	88	85	97%	✓	↓
Prevent Awareness	89	86	97%	✓	↑
Safeguarding Children Level 1 and 2	526	500	95%	✓	↑
Safeguarding Children Level 1	89	84	94%	✓	↑
Moving and Handling - Loads - Group 3	382	350	92%	✓	↑
Safeguarding Adults Alerters	89	82	92%	✓	↑
Smoking Cessation Level 2	12	11	92%	✓	↑
Prevent Workshop	526	478	91%	✓	↓
Infection Control Level 1	349	310	89%	✓	↓
Clinical Supervision	128	114	89%	✓	↑
Equality, Diversity and Human Rights	615	535	87%	✓	↑
PSTS Awareness/Conflict Resolution	73	63	86%	✓	↑
Dual Diagnosis - Level 1	210	180	86%	✓	↑
Information Governance	615	523	85%	✗	↑
Clinical Risk	492	416	85%	✗	↓
Fire Safety Awareness	615	517	84%	✗	↑
Health, Safety and Welfare	615	515	84%	✗	↓
PSTS Team Work	6	5	83%	✗	↑
Safeguarding Adults Alerters Plus	526	430	82%	✗	↓
Basic Life Support - Group 2	521	424	81%	✗	↑
Smoking Cessation Level 1	524	421	80%	✗	↑
Mental Health Act Training	245	196	80%	✗	↓
Moving and Handling - Patients - Group 2	232	184	79%	✗	↓
Mental Capacity Act (MCA)	428	335	78%	✗	↓
Fire Warden	81	63	78%	✗	↑
Infection Control Level 2	266	204	77%	✗	↑
Immediate Life Support	4	3	75%	✗	↑
PSTS Disengagement	537	394	73%	✗	↑
Risk Management	40	29	73%	✗	↑

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met	Compliance change when compared to previous year
Health and Safety for Managers	152	109	72%	✗	↑
Deprivation of Liberty Safeguards (DoLS)	526	370	70%	✗	↓
NEWS	3	1	33%	✗	N/A
Total	**9613**	**8026**	**83%**		↑

Assessing and managing risk to patients and staff

Assessment of patient risk

At our previous inspection in July 2017, we told the trust they must ensure all patients have a current risk assessment and risk management plan in place. At this inspection, we found although there were some improvements, this was still an issue. We reviewed 90 care records and found 15 records across the teams where staff had not updated the patient's risk assessment. This included when the patient had been discharged from an inpatient ward, to reflect the fact a change on the patient's circumstances who was now considered to be at high risk or when a safeguarding referral had been made. It was not clear from the risk assessment document when it had been last reviewed or updated with new information, as staff did not always input the date. Where the risk assessments had not been appropriately updated it was clear from other records in the patient notes that most staff had assessed risks to the patient whilst they were in the community.

The trust told us that their risk assessment policy at the time of the inspection did not say that a risk assessment review was mandatory unless the patient was new to the community team. Since our inspection, the trust has amended their policy to state that risk assessment reviews should be completed for existing service users being discharged back to community teams from within the trust.

Management of patient risk

At our previous inspection in July 2017, we were particularly concerned about risk management records in the Lambeth early intervention team. At this inspection, there had been an improvement in the management of patient risk. We reviewed nine care and treatment records in the Lambeth early intervention team. Six records had appropriate current risk assessments and management plans. In two records, staff had not updated the patient's risk management plan since they had been transferred to the team from the inpatient ward. Another record had a risk assessment with only historical risks and did not identify current risks or have a risk management plan.

At this inspection, we found that overall the Lambeth early intervention team, and the other community mental health teams were able to promptly respond when a patient's mental or physical health deteriorated or risks to self or others increased. All teams held daily multidisciplinary meetings at the start of the day to review and manage risks to patients. Staff rated risk as red, amber or green (red being high risk). Where risks had been assessed as high the multidisciplinary team kept the patient under daily review. In some teams, managers ensured that risk assessments and management plans were updated immediately during the daily multidisciplinary meetings. Where risk management plans were not up to date it was evident from progress notes that the care co-ordinator was working with the patient to manage current risks.

In most cases, staff had ensured that the patient had a crisis plan with details of what they should do if they felt their mental health had suddenly deteriorated. Crisis plans had information on the local emergency contact lines and emergency facilities.

Staff in all the teams followed trust procedures to ensure they were as safe as possible when making home visits.

At our previous inspection in June 2017, we were concerned about the delays in arranging Mental Health Act (MHA) assessments for patients in the community when their mental health was deteriorating. We told the trust that it must ensure that MHA assessments are carried out as promptly as possible to ensure the safety of patients and others.

At this inspection, we found that the trust had worked effectively with partner organisations to reduce risks to the safety of patients and others. However, there were still significant delays to MHA assessments.

There was a high volume of MHA assessment referrals due to the high level of mental health needs in the local community. Local authority staff responsible for arranging MHA assessments told us the primary causes of delay continued to be patients not being home or the availability of police. The police in each borough had agreed with the local authority that they would provide a fixed number of time-slots each week when they could guarantee police staff would be available to assist with an MHA assessment. However, the assigned police staff were unable to meet this commitment if, on the day, they were required elsewhere.

The approved MHA assessors would then have to be re-book the assessment into the next available police slot, which was likely to be at least two weeks ahead. Consequently, we were told that an MHA assessment requiring police assistance usually took between two and four weeks to arrange.

The trust collected information from on the reasons why initial planned MHA assessments were cancelled. This showed that from January to March 2019, 11% of initial planned Mental Health Act assessments were cancelled due to no bed being available, this was an improvement on the 21% in the previous quarter. The unavailability of police was responsible for 31% of delays in January to March 2019, up from 17% in the previous quarter. In 2018/19, 50% of rebooked assessments took place within 13 days of the initial cancellation, and 70% took place within 28 days.

During this inspection, we heard of some situations where physical health and mental health risks had worsened whilst an MHA assessment was pending. However, both trust staff and local authority staff said there had been significant improvements in managing risk since our previous inspection. The board and senior managers had good oversight of the issue and were regularly monitoring cancellations. This was due to better communication and planning between the trust, the local authority and the police. For example, community team staff in Lambeth said they were now able to escalate concerns about risk more effectively with the local authority and the police. This meant that in situations of extreme risk, MHA assessments could be arranged more promptly.

Staff access to essential information

Staff used the trust's electronic database to record and store information. All staff, including agency staff, could easily access and use the database. Information about the patient's previous contact with trust services was readily available.

Safeguarding

Staff completion of mandatory training courses in adult and children's safeguarding across the service was at 92% or above. All the staff we spoke with understood how to recognise and report abuse. All teams had effective liaison arrangements with the local authority to ensure adults and children were protected from harm. For example, in Lambeth social workers from the local authority attended a multidisciplinary meeting each week to review safeguarding plans and discuss any new referrals.

Patient records showed that staff had made referrals appropriately to safeguard adults and children. The service made 297 safeguarding referrals between 1 February 2018 and 31 December 2018.

Medicines management

The service prescribed, stored, recorded and gave medicines safely. Medicines were prescribed appropriately in accordance with national guidance. Medicines were kept securely and at the correct temperature. Medicines administration records for patients who were attending the depot clinics at each site were well-completed. Staff sometimes administered medicines to patients in their own homes. Staff followed trust procedures and transported medicines safely.

However, improvements are needed for medicine management audits, monitoring of prescribing and prescription stationery management. Staff were not following the Trust's policy to log and track the usage of individual prescriptions. This meant that there was a risk that the trust could not be certain that prescription pads had not been mislaid or stolen.

There was no process to monitor prescribing of antipsychotic medicines was compliant with Community Treatment Orders (CTO) for patients. Consultant psychiatrists prescribed antipsychotic and medicines for physical health on prescriptions dispensed by community pharmacies. However, there was no audit or prescribing analysis carried out to ensure this was appropriate or met national guidance.

The trust auditing processes were ineffective and were not imbedded into the culture of the services. The trust could not demonstrate that they had oversight of medicines management across the community services. However, staff did tell us that there were plans to increase clinical pharmacy input in community services. In Croydon, staff did not record when medicines were removed and returned from the medicines cabinet to take on home visits. This meant there was no way of knowing what medicines should be in the medicine's cabinet at any one time.

Since our inspection, the trust told us that they have reviewed and updated their medicines management and waste management policies.

We saw an example of good practice at the Lambeth recovery team who delivered a monthly depot clinic. Patients remained in the service for three hours, so staff could carry out physical health observations. This was delivered as a joint session with occupational therapists who arranged arts and craft activities to keep patients engaged during this time.

Track record on safety

Between 1 January 2018 and 31 December 2018 there were 47 serious incidents reported by the service. Of the total number of incidents reported, the most common type of incident was 'Apparent/actual/suspected self-inflicted harm meeting SI criteria' with 34.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff told us they were familiar with the trust's incident reporting procedures and could easily report incidents. For example, staff raised an incident when a Mental Health Act Assessment did not take place as planned. Staff recognised and reported incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff were aware of their duties in relation to the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers used the learning from incidents to make improvements. We found several examples during the inspection. In Lewisham, a finding following a

serious incident was that there was not a robust handover between care co-ordinators. The teams were now using a standard case handover form that has essential information, including details of the patient's circumstances and risks. In Southwark, teams were committed to involving patients' families more in care and treatment after a learning from deaths review had raised a concern about this. In Croydon, the early intervention team now always ensured they provided ongoing contact and support for the patient whilst they waited for transfer to another team.

Staff told us the trust promoted the reporting of incidents. They said they were reminded to do so through emails and team meetings. Information on the learning from incidents was produced centrally by the trust and circulated to all teams. Notes of team meetings showed that learning from incidents was discussed.

Staff told us they received appropriate support from their managers when adverse incidents occurred. Staff were debriefed and received support after a serious incident Managers arranged de-briefing sessions for staff who had been involved in an incident. Teams held reflective practice sessions facilitated by an external practitioner. These sessions provided an opportunity for staff to discuss incidents in a supportive environment.

Is the service effective?

Assessment of needs and planning of care

At our previous inspection, in June 2017, we told the trust that it must ensure that each patient has a comprehensive and person-centred care plan. At this inspection, we found the trust had made improvements. Now, most patients had a comprehensive mental health assessment and a holistic care plan which demonstrated input from the patient. However, we found examples in several teams where community team staff had not updated the care plan document since the patient had been transferred to the team from an inpatient ward, even though the community team worker had been working with the patient for several months. In these cases, there was evidence in the progress notes and elsewhere in the records that the care coordinator was working with the patient to support their recovery.

At our previous inspection, we found that in the Lambeth early intervention service, five of 16 care records did not include a care plan. At this inspection, we found there had been improvement. Now, in this team, eight of the nine records we checked included an appropriate comprehensive care plan. However, one patient's care plan had not been updated since they were discharged from the ward.

There were examples in each team of highly personalised care plans with detailed information about how individual needs would be met. Care records showed staff ensured that patients' physical health needs were identified on assessment and met by working in partnership with the patient's GP and others. For example, the Southwark early intervention team staff had involved the perinatal mental health service in developing a care plan for a pregnant patient. This plan included arrangements for specialist midwives to monitor the patient during their pregnancy.

The trust had clear procedures and protocols for early intervention services and community mental health teams on physical health screening which reflected NICE guidance. Teams had data on their current performance against the target for completing trust physical health screening documentation. Data showed that performance in this area was improving. However, most teams were still under the trust target. Team managers were supporting teams to improve their performance in this area and were confident that trust targets would be reached before March 2020.

Best practice in treatment and care

Staff provided a range of treatment and care for the patients based on national guidance and best practice. For example, the early intervention teams provided a wide range of NICE recommended evidence-based psychological, psychosocial, pharmacological and other interventions, including support for families and carers.

Since our last inspection in July 2017, there had been an increase in psychology input to some teams. Group therapy initiatives and other schemes, such as on-line therapy had been developed to reduce waiting times for psychology. However, at this inspection, staff told us that some patients in early intervention teams could still have a wait of over a year for individual therapy. Staff said that whilst patients were waiting for individual therapy, they were offered face-to-face support from a care coordinator and other types of intervention.

Many of the patients using the service had substance misuse issues. Staff had skills and experience in working with patients with a dual diagnosis. Teams had close links with local substance misuse services and supported patients to access appropriate help and support.

Staff referred patients to a variety of organisations to ensure their needs were met. Patients were able to access support and activities in relation to health and fitness, leisure, education and training, employment, welfare rights and housing. Provision in each borough varied and staff had detailed knowledge of the local resources available. Patients told us that staff had put them in touch with services that understood their needs and supported them with their recovery. For example, a patient told us that their care coordinator had helped them to find accommodation when they were homeless.

When a patient required specific physical health checks, such as blood tests, because of the medicines they were prescribed, psychiatrists had liaised with the patient's GP to ensure the appropriate medical monitoring occurred. Staff ensured that patients' physical healthcare needs were met, through an annual health check. Staff could view GP records through an electronic portal system.

Staff supported patients to live healthier lives. Staff offered patients help and advice on smoking cessation. For example, the Southwark north-west promoting recovery team provided a smoking cessation project. The service had surveyed its patients and found that 50 of their 218 patients smoked. The service set up a support group for these patients with assistance from the trust's smoking cessation lead. This service had also supported a patient with cancer. The care co-

ordinator had attended appointments with the patient from the initial screening session through to the completion of treatment.

All the teams used health of the nation outcome scales to measure the outcomes of the service.

Staff used technology effectively to support their work with patients. For example, clinicians could access GP records through the local care records system. Some teams were able to update patient records when working off-site.

A wide range of clinical audits were carried out across the service. There were trust-wide audits of patient records and medicines audits. For example, each team manager checked a sample of ten patient records each month and identified any areas for follow up. Quality improvement initiatives were in progress in some teams. For example, the Southwark assessment and liaison team had carried out an initiative to show the pattern of accepted and declined referrals from each GP cluster. This enabled the service to identified GPs who were making inappropriate referrals and work with the GP to improve their understanding of the service.

We identified good practice in the Lambeth promoting recovery team monitoring and auditing of community treatment orders (CTOs). The trust told us after the inspection they were taking action to distribute the audit tool across all operational directorates.

Skilled staff to deliver care

Staff of different kinds worked well together to provide effective care and treatment. All the teams were multidisciplinary. Staffing establishments varied from team to team, but included registered nurses, psychiatrists, doctors, support workers, psychologists and occupational therapists. Teams had close links with social workers working in the local authority who undertook Health and Social Care Act assessments.

Staff told us that they found their colleagues to be skilled and experienced. They said that induction processes were thorough for both agency and permanent staff. Staff told us there was an extensive range of mandatory and specialist training on offer to develop their professional competence.

Managers supported staff with their well-being and professional development. They ensured that staff worked with patients in a focused way with a clear plan and objectives. Records showed that staff received clinical supervision every four weeks. Supervision records were comprehensive, covering staff well-being and development needs, and a review each patient on the supervisee's caseload. Progress with casework was reviewed and managers supported staff with any problems or barriers to achieving positive outcomes for patients. This ensured that staff worked in a recovery focused way and patients were discharged from the team appropriately. Staff had an annual appraisal of their work performance which included feedback from their manager on their competence and a personal development plan. Staff told us that their clinical supervision was helpful and supportive. In most teams, staff also had the opportunity to attend reflective practice sessions facilitated by an external professional.

Multidisciplinary and inter-agency team work

Each team had their own weekly schedule of multidisciplinary team meetings throughout the week. These different multidisciplinary team meetings had a specific function and agenda. These meetings ensured there was prompt discussion and planning in relation the screening and allocation of new referrals and the management of high-risk cases. All teams used multidisciplinary meetings effectively to manage duty work and safeguarding issues and to discuss

complex cases. Teams also planned how to ensure the transfer of patients who were in hospital back to the team and discussed the discharge of patients from the team.

Teams had strong links with the mental health wards which admitted patients from their area. Team managers attended bed management meetings to ensure that there was early identification of new patients for allocation to their teams. Additionally, the allocated care co-ordinators attended ward rounds and discharge planning meetings to ensure that patients could be safely discharged without delay.

Teams worked effectively with home treatment teams and other specialist trust teams. Staff told us that the trust's change to borough-based directorates had facilitated stronger networking with local statutory and voluntary agencies. For example, in the Lambeth teams, a social worker from the local authority attended one of the multidisciplinary meetings each week to ensure safeguarding and Care Act assessment work was well coordinated. Some teams had three monthly meetings with GPs. Staff across the teams were confident that borough-based working would strengthen inter-agency work in future.

Adherence to the Mental Health Act (MHA) and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities in relation to the Mental Health Act. They received training on the Mental Health Act. We checked patient records where the patient was subject to a community treatment order. Paperwork relating to the community treatment order had been scanned onto the electronic patient record and was generally up to date. In most cases, there were records to confirm that staff had informed patients of their rights, although this information was not always located in the same place in patients' records. We saw several examples where staff had supported the patient to access legal advice with their appeal against a community treatment order and to attend a hearing.

The trust had designed an audit tool which enabled team managers to check full compliance with the Mental Health Act in relation to community treatment orders. During the inspection we identified that not all teams were carrying out these audits effectively or following up on identified issues for action in a timely way. Consequently, we found examples where there was no record of the patient having been informed of their rights when a community treatment orders was renewed. Additionally, there were cases where the responsible clinician had certified that the patient consented to treatment without recording their discussion with the patient. The Mental Health Act code of practice states a record of their discussion with the patient including any capacity assessment, should be recorded in addition to the completion of the certificate.

Good practice in applying the MCA

Staff understood their roles and responsibilities in relation to the Mental Capacity Act. Training in the Mental Capacity Act was mandatory. Staff put into practice the five statutory principles of the Mental Capacity Act. Staff assessed patients' mental capacity to make significant decisions in relation to their physical health and their finances. For example, staff were concerned about a patient's mental capacity to fully understand the consequences of not taking medicine for a physical health condition. The psychiatrist completed a full assessment of the patient's mental capacity in relation to this decision and concluded that they did have capacity. In response, staff continued to encourage the patient to take the medicine and monitored the patient's physical health.

Staff supported patients who may lack mental capacity to fully participate in decision making. For example, staff arranged for a patient to be supported by a psychiatrist from their own cultural background in relation to deciding about surgery.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Staff spoke about patients in a kind and respectful way. We saw that staff asked patients how they could help them, responded to patients' wishes and provided reassurance when patients were anxious.

Patients were very positive about the attitude and behaviour of staff. They told us they found services to be welcoming and commented on the friendliness of reception staff. Patients said all the staff in the teams were respectful, helpful and caring. They told us that they were able to see their care coordinator when they needed to. Patients said staff took the time to get to know them and to understand their individual needs and circumstances.

Care records showed that staff supported patients to understand and manage their mental health and physical health needs. Staff provided individual and group interventions for patients to learn about their mental health and their recovery. Patients told us they were able to ask staff questions about their care and treatment.

The trust collected regular feedback from patients about their experiences of care and treatment. Almost all patients said that staff were kind and caring.

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff maintained the confidentiality of information about patients.

Involvement in care

Involvement of patients

Staff involved patients in care planning and risk assessment. Patients told us that staff asked them about their views and preferences. They said they were able to discuss their care and treatment with their psychiatrist and care coordinator at review meetings. Records showed that staff considered patients views about how they wanted to receive their care and treatment. Staff were flexible in terms of appointment times and locations, for example. Staff wrote care plans as if the patient was writing them, although it was not always clear from the records how staff had worked with the patient to develop the care plan with the patient. Nor was there a standardised method for staff to record that the patient had been given a copy of the care plan. Some patients told us they were not offered a copy of their care plan.

The trust had an involvement register and patients were involved in the recruitment of staff and consultations about service developments.

Teams responded to patient feedback. For example, in Lambeth, the early intervention team, at the request of patients, had extended clinic times to provide a service in the evenings.

Involvement of families and carers

Staff informed and involved families and carers appropriately. Staff asked patients who was important to them and how the patient would like the team to communicate with their family and others. Care and treatment records showed that, when appropriate, staff worked closely with the

family and carers, involving them in meetings and interviews to discuss the patients care and treatment.

Staff supported carers to access a carer's assessment and gave information on local support groups for carers. Some teams arranged carers support groups and events. Carers told us that they found that staff were responsive when they contacted the team and gave them the support and information they needed.

Is the service responsive?

Access and waiting times

Community mental health teams were easy to access. The service had operational policies which specified referral criteria and did not exclude people who would have benefitted from care. The trust had target times from referral to triage/assessment and from assessment to treatment. At our previous inspection, and at this inspection, in most teams, targets were met. Staff assessed and treated patients who required urgent community care and treatment promptly. In most teams, patients who did not require urgent care did not wait too long to start treatment.

The trust has identified the below services in the table as measured on 'referral to initial assessment' and 'referral to treatment'. The service met the referral to assessment target in all the targets listed. The number of days from referral to the onset of treatment ranged between eight to 13 days (no target applied).

Name of Team	Please state service type.	Days from referral to initial assessment		Days from referral to treatment	
		Target	Actual (median)	Target	Actual (median)
Croydon Adult - COAST	Croydon	14	8		8
Leo Community Service	Lambeth	14	10		10
Lewisham Early Intervention Service	Lewisham	14	13		13
STEP	Southwark	14	9		9

** The median of waiting is not what the National Standard is measuring; it is expecting 50% of referrals to be seen within 14 days, not a median of waiting time for all referrals

At our previous inspection in 2017, we found that the Croydon assessment and liaison team was unable to meet their target for assessing non-urgent referrals within 28 days. At this inspection, we found that this continued to be the case and the team had a current waiting list of over 550 non-urgent cases awaiting a face-to-face assessment. Staff and managers told us that they had worked hard to reduce the waiting list from over 900 to 564. Staff told us that these patients had been risk screened and risk assessed via telephone triage. Staff told us that this helped identify anyone in need of urgent assessment. If risks had increased assessments were brought forward. Patients waiting for a non-urgent assessment were placed on a practitioner's caseload. The Croydon team were introducing a caseload management tool and improved supervision template. Staff reviewed caseloads continuously and consultants offered caseload reviews every three months. In the last six months, patients in Croydon waited an average nine weeks for a non-urgent assessment. Lambeth, Lewisham and Southwark were generally able to meet the 28-day target. The trust told us that they were in the process of sending a letter to all patients on the Croydon assessment and liaison team waiting list with information on how to access help if their

circumstances changed. They were also increasing the staffing resource in this team and at referral and screening and were trialling a GP Advice Line to supplement the current advice given. The general manager and deputy director of Lambeth community services monitored the Lambeth assessment and liaison team waiting times fortnightly. They worked with the team to address any potential barriers to achieving the waiting time standards. The senior management team reviewed team caseloads at monthly business and performance governance meetings, and at performance and quality reviews, escalating on-going concerns or blocks when needed. The trust was also actively involved in the clinical commissioning groups' redesign of community services.

Teams were able to promptly respond to urgent cases. Teams held daily multidisciplinary meetings to decide whether to accept new referrals and plan how the patient should be assessed. Staff had duty systems which ensured that staff were always available to respond to urgent referrals. Duty workers responded to patients who visited services without an appointment and provided cover when care coordinators were away. They could respond quickly to patients experiencing a crisis and could make home visits where necessary. Staff checked that risks had not increased when there were waiting lists for non-urgent assessments. Patients and carers told us that the teams were responsive when they telephoned for advice and support.

Relationships with inpatient wards and other mental health teams within the operational directorates were improving. Closer networking between managers, who met regularly meant that any difficulties in transferring cases between teams could be resolved.

Staff made repeated attempts to make contact and engage with patients. Staff used text messages, phone calls, letters and unannounced visits. Staff used multidisciplinary team meetings to discuss risks and plan alternative interventions when patients did not wish to engage with the service.

Patients told us that staff were reliable and kept appointments. Teams were flexible about the timing and location of appointments and offered evening appointments when necessary.

Staff supported patients during referrals and transfers between services. For example, staff kept in touch with patients who were in hospital. The early intervention service in Southwark employed a social worker jointly with the Child and Adolescent Mental Health Service to support patients through the transition from children's services to adults' services.

Facilities that promote comfort, dignity and privacy

All teams had suitable premises which were appropriate for providing treatment and care. Interview rooms had adequate soundproofing.

Patients' engagement with the wider community

Staff were familiar with the available resources in their local area and made sure that patients were introduced to them. These resources included agencies that helped with leisure activities, education and finding work. Patients were positive about the way staff had helped them to access opportunities and promote their recovery.

Staff asked patients about the people who were important to them, and with their permission, supported them to keep in touch with them.

Meeting the needs of all people who use the service

The service was able to meet the needs of patients with physical disabilities. If a patient was unable to easily visit the service staff made alternative arrangements. Staff gave patients written information about the service, local resources and how to complain. We saw that reception areas had a wide range of leaflets and posters on display for patients, including information on advocacy. Staff told us they could easily access an interpreter when this was required.

Teams helped to develop and participated in many different events to celebrate diversity. For example, in Lewisham, staff involved patients and their families in planning and delivering events for black history month. Staff ensured that patients could access appropriate support with their diverse needs. For example, staff referred patients to relevant agencies in relation to gender identity and sexuality issues.

Listening to and learning from complaints

Patients told us they knew how to make a complaint. This service received 196 complaints between 1 January 2018 to 31 December 2018. Forty of these were upheld, 50 were partially upheld and 51 was not upheld. One was referred to the Ombudsman.

Team managers followed trust procedures to log and respond to formal complaints. Additionally, they ensured that patients and carers could raise any concerns with them at the earliest possible stage. Often concerns and complaints were about communication issues between staff and patients. Managers told us how they met with patients and staff to clarify issues and to ensure a positive outcome.

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles. All the team managers in were registered health professionals with extensive experience of working in community mental health services. Team managers and more senior trust managers had ensured improvements had been made since our previous inspection of the service in 2017 and no new concerns were identified at this inspection.

Managers were well informed about the operational performance of their team and any areas for improvement. Staff said that team managers consistently demonstrated their leadership and commitment and made themselves available to staff for advice and support. All managers were based within the services they managed and worked directly with care co-ordinators each day. Staff said managers were hands-on and when necessary would undertake direct work with patients.

Leadership training and development opportunities were available, including opportunities for staff below team manager level. Leadership training was available to non-managerial staff. Many staff within the services had achieved promotions. Managers said they were given opportunities to developing their leadership role through their involvement in local inter-agency development work.

Vision and strategy

The trust’s senior leadership team had successfully communicated the provider’s vision and values. Staff understood the trust’s vision and values and how they applied to their work with patients.

At the time of this inspection, community mental health services were undergoing transformation to a more localised borough-based approach. Staff told us the trust had kept them fully informed of the changes taking place in their local area through regular meetings and consultation events. They said they felt involved in decision making. Most staff told us they were positive about the way the trust and its partner organisations were making these changes which felt would improve outcomes for patients and staff.

Culture

Staff felt respected, supported and valued. They told us they felt supported by their managers and colleagues. We saw that staff supported each other in relation to managing risks and covering for colleagues who were unavailable. Staff said that they had enjoyed team development events.

Staff were very positive and committed to their work and proud to be part of their team. They said they felt able to raise concerns without fear of retribution. All staff said they would feel able to discuss any concerns with their manager. Staff knew how to use the whistleblowing process and were aware of the role of the trust's freedom to speak up guardian.

Managers and staff told us that any issues of poor staff performance or other staff difficulties were dealt with. Managers could access support from senior managers and trust specialists if there were concerns about performance or team dynamics.

Staff appraisal records included conversations about career development and how it could be supported. The trust had some schemes to promote equal opportunities. For example, there was a talent management course for black and minority ethnic nurses within the trust.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The service's staff sickness and absence rates were similar to the provider average.

Staff told us that team managers celebrated team success at team meetings. The trust held an annual staff awards event. Staff could nominate teams or individuals for awards such as kindness and caring, transforming lives and the team of the year.

Governance

Governance was effective across the teams. We found teams to be well-staffed and located in premises that were safe and clean. Teams had a good understanding of their role in the care pathway and had positive working relationships with GPs, other community teams and inpatient services. Since our last inspection, staff had improved their record keeping. In most cases, referrals were responded to effectively and assessments arranged in a timely way. Staff had begun a process to ensure that physical health screening was carried out effectively. Where there was a difficulty in meeting a target, managers were aware of the issue, working to make improvements and ensuring risks were mitigated.

Teams held a monthly business meeting. There was a standard agenda for these meetings covering feedback from patients, learning from incidents and complaints and organisational developments. These meetings were well attended, and notes were kept for staff who were unable to attend and to ensure any follow up actions took place.

Management of risk, issues and performance

Staff could escalate concerns to the trust risk register when required from a team level. Senior managers were well informed about risks. There was a combined risk register for all the trust

mental health services across each borough. For example, the February 2019 Lambeth directorate risk register included risks in relation to the permanent staffing of Lambeth community teams, the risk of patients not being informed of their Mental Health Act rights and the risk of staff not fully delivering improvements to risk assessments and care plans. There were action plans in place to deliver improvement and we saw that there had been improvements to the quality of the service since our last inspection.

Information management

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. Team managers had access to a dashboard of data showing caseloads, waiting times, the number of patients under the Mental Health Act and the number of patients in hospital. The same information was available to care co-ordinators in respect of their own caseload.

Team managers said the dashboard had some good features such as showing the last date the care coordinator had face to face contact with a patient. However, it did not show the date of the last care plan or risk assessment only highlighting if these documents were more than 12 months out of date. This meant that managers had to review patient records in detail to see if the care plan or risk assessment reflected the current situation.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the provider and the services they used. The trust and local partner organisations had fully involved staff, patient's and carers in developments to the service and changes to provision at the borough level. The trust supported service user and carers forums in each borough. These forums were actively involved in the review of service quality and in planning service development. Patients and carers were able to report back to trust senior managers at involvement events.

Patients and carers had opportunities to give feedback on the service. Staff encouraged patients to complete questionnaires on the electronic feedback system. The trust collated feedback from patients, carers and staff and sent this to team managers. It was used it to make improvements. For example, some teams had extended opening times in response to feedback from patients. team meetings.

Directorate leaders engaged with external stakeholders, such as commissioners, GPs and voluntary organisations at consultation events.

Learning, continuous improvement and innovation

Staff said there were opportunities for them to be involved in quality improvement initiatives. Staff had developed projects with the aim of improving outcomes for patients. For example, in Southwark there was a project on improving patient awareness of diabetes prevention.

Perinatal services

Facts and data about this service

South London and Maudsley Foundation Trust provides an inpatient Mother and Baby Unit (MBU) and community based perinatal mental health teams for the London boroughs of Croydon, Lambeth, Lewisham and Southwark. Perinatal services come under the trust's Psychological Medicine and Older Adults directorate.

The MBU offers multidisciplinary mental health assessments, treatment and support for women from all over the country and is based at the Bethlem Royal Hospital. It provides support to women during pregnancy and in the 12 months following the birth of their baby, with beds for up to 13 patients and their babies. The team are also able to provide one bed for a parenting assessment on the unit.

The community perinatal mental health teams offer multidisciplinary specialist assessment, care and treatment for women who are pregnant or have a baby up to 12 months old and are experiencing mental health problems that are moderate or severe in nature. They also provide preconception advice for women with mental health issues.

The teams mainly receive referrals from a wide range of sources including GPs, community mental health services, maternity, general or mental health inpatient wards.

This was a comprehensive unannounced inspection over three days.

We inspected these services:

- The Channi Kumar mother and baby unit (MBU)
- Croydon Perinatal mental health community team
- Southwark Perinatal mental health community team
- Lambeth Perinatal mental health community team
- Lewisham Perinatal mental health community team

Is the service safe?

Safe and clean environment

Safety of the ward layout

The Mother and Baby Unit (MBU) had current environmental risk assessments and staff completed regular environmental checks of the ward environment. Staff we spoke with were aware of the risks around the ward and how to mitigate them. The service ensured new staff members, students and bank/agency staff were made aware of potential ligature anchor points on the ward by covering this as part of their induction. Current ligature anchor point risk assessments were in place including photographs of potential risk points. All staff had signed to confirm that they were aware of these risks.

The bedrooms on the MBU were located off two long corridors from the nurse's office and separated by fire doors. There were some blind spots on the ward along the corridors. Staff said they mitigated these by doing regular environmental checks of the areas. There were also convex mirrors to provide staff with improved lines of site.

The ward had a current fire safety management plan, and staff recorded fire safety checks covering the fire doors, fire safety equipment, alarm systems and signage. The most recent fire safety audit was undertaken in November 2018, and fire drills were carried out on a regular basis.

The wards complied with guidance on eliminating mixed-sex accommodation, as it was a female only ward. There were visiting hours in place for patients' partners visiting the service.

All staff carried personal alarms and there were panic alarms in all patients' bedrooms. In the event of an emergency the MBU was part of the hospital emergency team system and would receive support from staff on other wards. Two emergency baby bags and suitcases (stocked with formula, nappies and other essentials) were maintained, in the event of having to relocate from the building in an emergency.

Staff working at the community perinatal teams including reception staff, told us that they felt safe. Staff controlled entry to the premises. Interview rooms were fitted with alarms that staff could use in an emergency. Staff made checks to ensure the alarms were working and practised how to respond to an alarm.

Maintenance, cleanliness and infection control

All areas of the MBU were clean, had sufficient furnishings and were well maintained. Staff adhered to infection control principles, including handwashing. Staff described how they recently worked with the trust's infection control team to manage cases of norovirus and chicken pox on the ward to ensure the safety of patients and staff.

The most recent Patient-Led Assessments of the Care Environment (PLACE) assessment was carried out in 2018. The Bethlem Hospital achieved a score for cleanliness of 98% and a score for condition, appearance and maintenance of 95%.

Ward areas were cleaned regularly by contractors. Staff conducted weekly audits of the cleanliness of the unit, including checking beds, mattresses and pillows. The modern matron for the MBU was working to address some issues of cleanliness picked up in recent audits. A housekeeper position had recently been agreed for the ward to address this issue.

Community perinatal teams were based in premises which were clean, but not always well maintained. Staff told us that maintenance issues were not always addressed promptly. There had been a recent fruit fly infestation in the Lambeth perinatal team, which was addressed, and an ongoing issue of mice, due to the proximity of the building to the river, which was being monitored by a pest control service.

Clinic room and equipment

The clinic room at the MBU was equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff recorded checks of the emergency equipment bags each week.

The clinic room was clean and tidy, and air conditioned to ensure that medicines were stored at an appropriate temperature. Staff kept records of the clinic room temperature and the temperature of the medication fridge, indicating that these remained within an appropriate range. Staff received training in using medical devices appropriately. We saw records to confirm that all equipment was serviced regularly and calibrated, including suction equipment, and weighing scales.

The clinic room included relevant flow charts on its walls, for example regarding wound care, and the trust tissue viability pathway.

The community perinatal mental health teams did not have clinic rooms.

Safe staffing

Nursing staff

The trust had an ongoing recruitment drive, however, staff told us that recruitment of staff with the required experience and skills, and staff retention was an issue across the service. The perinatal core service reported the below establishment and vacancies at the time of the inspection. They were unable to separate figures for Southwark and Lewisham which are currently reported together. The MBU had the highest number of vacancies with approximately 28% vacancies for registered nurses (5 out of 18 positions), and 16% vacancies for non-registered nurses. One of the nurse vacancies had been recruited to at the time of the inspection. Most vacancies were filled by bank staff. The MBU ward manager reported difficulties appointing appropriate candidates to the vacancies but was working with the trust to hold specific recruitment days for this specialist ward. The ward used regular bank and agency staff who were familiar with the ward.

Of the non-registered nurses, 10 were qualified nursery nurses. Following a staffing review for the MBU, two months previously, a housekeeper position had been agreed for the service to replace a non-registered nurse post.

Minimum staffing levels on the MBU, when full, was three registered nurses, and four non-registered nurses during the day, and two registered nurses, and four non-registered nurses at night. The service reported unfilled shifts (by agency or bank staff) on the MBU of 12% in January, 21% in February, and 14% in March 2019.

The sickness rate for the last year to 28th February 2019, was 5% for the MBU, 1.7% for Croydon, 1.9% for Lambeth and 10.5% for Southwark and Lewisham combined.

This core service had 20% registered nurse staff leavers and 11% non-registered nurse staff leavers in the 12-month period to 31 March 2019. The MBU reported the highest turnover rate of 22% for both registered and non-registered nurses and recognised that this was still an area for improvement.

There was an interim clinical support lead in place for the community perinatal services. The community teams provided a plan for addressing vacancies in their teams, including recruitment of two permanent band 7 posts and one band 6 post to cover maternity leave, with dates in place for application shortlisting, and interviewing. Team managers alongside each team consultant reviewed the caseload for individual care coordinators twice monthly.

Team managers provided clinical supervision for staff which assisted them manage their caseload. Teams discussed general case load issues at zoning and team business meetings and looked at ways of making improvements.

Teams operated a duty service to ensure patients received a safe service. Care co-ordinators covered duty on rotation, so that there was always a member of staff available to respond to any urgent concerns. During the inspection, we observed that teams planned for duty staff to cover for sick or absent colleagues. Team managers and staff were flexible and supported the duty worker when necessary with urgent home visits.

At the time of the inspection, staff told us that there were vacancies for one band 7 nurse post in the Southwark perinatal community team, maternity cover for a band 6 nurse post, and a band 5 nursery nurse vacancy. Staff described additional pressures on the team, as some staff chose to reduce their hours, meaning more duty days for nursing staff. There were caseloads of approximately 23 for this team.

In Lambeth team there was a band 6 nurse vacancy, and a band 7 occupational therapist (care coordinator) vacancy. Caseloads were approximately 20 for this team.

In the Lewisham team there were two bank staff covering the caseload, and a permanent staff member due to go on maternity leave shortly, at which point the team leader would be the only permanent registered nurse in the team. Staff spoke of high pressures in this team due to vacancies, and long-term sickness. Unlike other team leaders, the Lewisham perinatal team leader had a full caseload of 25 in addition to covering duty for the team each day. In other teams, team leaders' caseloads were restricted to approximately 10 cases. Some staff in this team had caseloads of up to 35 at the time of the inspection. Staff told us that 25 was usually expected to be the upper limit for caseloads.

The trust provided their plan for addressing staffing issues in the community teams. In addition to recruitment, all bank/agency nurses received a team induction on their first day, reviewed over the first month in placement, regular supervision, and included in team training sessions. Team managers and the clinical support lead supported agency nurses with their caseloads by implementing the caseload weighting tool and reviewing actions.

Medical staff

There was adequate medical cover for the MBU during the day and night and a doctor could attend the ward quickly in an emergency. Two part-time consultant psychiatrists were in post, providing 1.2 whole time equivalent (WTE) posts. The service also had a full-time junior doctor, and a specialist registrar doctor on two days each week. Out of hours, the first level support was provided by two core trainee doctors on site at the hospital, then specialist registrars, and finally by generic mental health and specialist consultants when needed.

All patients at the MBU could visit a local GP surgery for any physical health issues for themselves or their babies. The MBU also had weekly support from link health visitors, and a midwife. In an emergency, staff could contact paediatricians at Croydon Hospital.

The community perinatal mental health teams that had received Wave 1 funding, (all other than the Croydon team which was receiving funding under Wave 2) had the equivalent of approximately one WTE consultant psychiatrist in post. In the Lambeth team, the two consultants providing this cover were due to leave shortly after the inspection, and the post was being recruited to. In each team staff told us that Wednesday was the day that it was hardest to find medical cover as trainee doctors had training on this day, so only on-call medical cover was available.

Mandatory training

The compliance for mandatory statutory training courses at the time of the inspection was 83% for staff on the MBU. This was below the trust target of 85% compliance with mandatory training. Where training was incomplete, the manager reminded staff during supervision and the trust prompted them via email alerts to complete training. Staff reported that some mandatory courses were oversubscribed, which could lead to delays in completing training. The lowest rate of training 40%) was for promoting safe and therapeutic services (PSTS) awareness and conflict resolution. The unit manager advised that although staff were expected to undertake this training, PSTS had not been ratified for use with pregnant patients.

For community perinatal teams, Croydon reported 90% mandatory compliance with, only 57% staff trained in health, safety and welfare, and 67% in basic life support. Southwark and Lewisham community perinatal teams reported 88% mandatory compliance, and Lambeth reported 93% compliance.

Assessing and managing risk to patients and staff

Assessment of patient risk

We looked at four patient care records on the MBU, of which two were for patients detained under the Mental Health Act. Staff completed a risk assessment of every patient on admission and updated it regularly, including after any incident. A summary of risks was included in the initial assessment. Risk management was a high priority due to the presence of babies on the ward. Babies had to be well enough for them to be looked after in the community, before coming to the MBU.

Individual risks were discussed in multidisciplinary meetings, individual reviews, and handovers meetings. Staff used a red, amber, green rating system in place to identify patients at the highest risk levels.

Staff used the trust risk assessment tool on the electronic patient record. However, due to the complex nature of patients' needs, and parenting responsibilities, staff recorded further detailed information in patients' progress notes. Staff entered details of the patient's risk history, current risk and a risk management plan, in addition to plans in place to ensure their baby's safety. Babies had the status of 'guests' on the ward, and staff recorded a separate care plan for them.

We looked at 13 patient care records under the community teams, these were from the Lambeth, Lewisham and Southwark teams. Community teams assessed patients on a zoning red, amber or green rating system for risk. Staff saw and reviewed patients on a red rating weekly. Patients on an amber rating, those staff had some concerns about, were monitored regularly and reviewed regularly. The trust community risk assessment and management tools did not always fit the complex situations of pregnant patients or those with young babies. Staff therefore recorded more detailed assessments in patient's progress notes, and multidisciplinary meeting notes.

Management of patient risk

Each risk identified for patients and their babies, were addressed with a risk management plan to minimise their likelihood. There were some details recorded on the trust electronic care plan document, but these were largely recorded in patients' progress notes and multi-disciplinary team meeting records. Staff told us that there was a working group (led by a perinatal consultant psychiatrist) involved in producing a bespoke care planning format for the perinatal service, to address this issue.

Staff applied blanket restrictions on patients' freedom only when justified. All mothers at the MBU were on enhanced and then if appropriate general observations during their first three days on the ward. This was considered necessary to ensure the safety of all mothers and babies on the unit. Following this, staff undertook observations according to the policies and procedures of the trust. Patient observation levels were discussed and reviewed for their appropriateness as each handover and multidisciplinary team meeting. Blanket restrictions were consistent with the need to provide a safe environment. The service did not permit drugs, alcohol or sharp objects to be bought onto the ward.

Nurses reviewed patients' physical health needs using the national early warning score (NEWS).

Both in the MBU and in the community teams, staff identified and responded to changing risks to, or posed by, patients. Across all sites, individual risks and changing risks were discussed in multidisciplinary meetings, individual reviews, and handovers.

Staff adhered to best practice in implementing a smoke-free policy. The service provided nicotine replacement therapy to patients on request.

Informal patients could leave at will and knew that they were able to do so, and staff had clear information readily available to them about the legal status of each baby on the unit, and whether they could be taken outside, and by whom.

Staff spoke about robust lone working procedures when out in the community and would do joint visits or meet in public where there were any risks present. Staff were not aware that they could request GPS alarms for when carrying out visits. However, they said that they felt safe with the existing systems in place, with duty staff checking on the safe return of staff from each visit.

Staff ensured that when necessary, patients had a crisis plan in place with details of what they should do if their mental health suddenly deteriorated. For patients on the community teams who required support out of hours, staff signposted them to the psychiatric liaison teams, home treatment team, trust's crisis line and accident and emergency departments.

Use of restrictive interventions

There was no seclusion facility at the MBU, and staff were clear that they would not seclude any patient in their own room. Staff told us that if necessary they would use verbal de-escalation, giving a patient space, and access to the sensory room for as long as needed.

Staff rarely used restraint at the MBU, and when they did so, had a policy of never using prone restraint with pregnant patients. The trust taught staff to restrain pregnant women in the safest way possible and used a bean bag in the process.

The most recent restraint recorded was in November 2018. However, rapid tranquilisation had been used five times on one patient in March 2019.

Staff access to essential information

Staff used the trust's electronic database to record and store information. All staff, including agency staff, could access and use the database. Staff recorded information about patients and babies on electronic patient records.

All information needed to deliver patient care was available to relevant staff when they needed it and in an accessible form. The system showed details of entries made by staff within the trust, including entries made during admissions to other wards and entries made whilst patients were under the care of community mental health teams.

Incidents were recorded on a separate electronic recording system. Staff in the community teams told us that the electronic systems could be slow at times.

Some staff commented on the delays with getting IT equipment and the impact it had on their work. For example, the Croydon team had been waiting for laptops for months, so staff could do more remote working. One staff member said it took months before they were given a work mobile.

Staff in the community perinatal teams were able to access local records of patients in the hospital services in which they were based.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had received training on how to recognise and report child or adult abuse

and they knew how to apply it. Staff received training in both adults and children safeguarding level two and three.

Staff were aware of how to report a safeguarding alert and gave examples of referrals they had made. These included issues such as domestic violence, financial abuse, and historical abuse. Until recently each perinatal community team had access to a social worker, with whom they could liaise about safeguarding concerns. At the time of the inspection, staff said that they could contact their directorate safeguarding lead to obtain advice. Staff supported patients to liaise with other agencies such as courts and the local authority during their safeguarding investigations and beyond.

Staff at the MBU followed safe procedures for the babies, and other children visiting the ward, with access to a family room. We observed that they discussed safeguarding issues in ward rounds and at staff handover meetings. Staff were very clear about the status of each baby on the ward, for example if they were on a child protection plan or care order.

Staff had high rates of completion of mandatory training courses in adult and children's safeguarding across the service. The lowest rates were in safeguarding adults alerters plus, which had completion rates of 82% for the MBU, and 83% for Lewisham and Southwark community perinatal teams. All the staff we spoke with understood how to recognise and report abuse and reported that their teams had effective liaison arrangements with the local authority to ensure adults and children were protected from harm.

Patient records showed that staff had made appropriate referrals to safeguard adults and children. In the last six months this core service had made 13 child safeguarding, and two adult safeguarding alerts. Staff could give examples of safeguarding concerns in their teams and how these were managed. They met with the maternity ward midwives regularly to discuss any safeguarding issues.

Medicines management

The MBU prescribed, stored, recorded and gave patients medicines as prescribed. Medicines were prescribed appropriately and within the correct range in accordance with national guidance and considered for patients who were pregnant or breastfeeding. This included ensuring that patients were not over-sedated, so that they could care for their young baby.

Medicines were kept securely and at the correct temperature. We examined 11 medicines administration records at the MBU. Each chart included information about the patient's allergies, if breast feeding, and their mental health status. There was limited use of 'as and when' medicines at the unit. All medicines were administered by two nurses.

Babies had separate medicines charts and were on very little in the way of medicines, mostly topical creams.

The unit undertook regular gap audits, and the ward manager advised that the action plan for any medicine error, including failure to sign, included performance management of staff. This was confirmed in supervision records that we looked at. Charge nurses audited the clinic room, and medicines charts weekly, and acted to address any out of date medicines, missed doses or other medicines errors.

Pharmacists visited the MBU at least two or three times weekly, and patients could speak with them directly, regarding any information they needed about their medicines.

Track record on safety

In the last 12 months, there had been one serious incident reported by the service, shortly prior to the inspection, which was still being investigated.

In the community perinatal teams 24 incidents had been reported in the year, of which 15 related to the Lambeth perinatal community team.

Reporting incidents and learning from when things go wrong

Staff knew which incidents to report and how to report them on the trust's electronic reporting system. Incidents included self-harm, violence and aggression, reported abuse, infection control and IT issues.

Staff understood the duty of candour. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong. Staff we spoke with were aware of the need to be open and transparent with patients and carers should things go wrong. They gave an example of a recent incident at the MBU, where staff had failed to give a patient their prescribed medicines. Staff had apologised to and discussed this incident with the patient.

Staff received feedback and learning on incidents during handover, supervision, and team meetings. Managers investigated incidents and shared lessons learnt with the whole team and the wider service. The trust circulated 'blue light bulletins' detailing incidents that had happened across other parts of the trust.

Staff were debriefed and received support after a serious incident from a dedicated team within the trust to facilitate a critical incident support session. This provided the opportunity for staff to reflect upon and learn from incidents.

Staff in each team told us they received reflective practice with a psychologist to discuss incidents. They spoke highly of the support provided by their managers. Staff told us about learning from recent incidents including review of how patients with personality disorders are supported including more use of dialectical behavioural therapy skills, review of prohibited items at the MBU.

Is the service effective?

Assessment of needs and planning of care

We reviewed four care records within the MBU and 13 in the community perinatal teams. Although staff did not always use the trust forms to record care plans, we found detailed care plans recorded in patients' progress notes and multidisciplinary meeting records. The quality of assessments and care planning was good. A working group was looking to produce a bespoke care plan for use in the perinatal services.

There was a separate care plan recorded for the babies in the MBU, attached to the mother's electronic record. Within three days of admission to the ward, nursery nurse staff completed an admission summary for each baby including their weight and feeding needs.

On the MBU staff completed a comprehensive mental health assessment and assessed patients' physical health needs promptly after their admission. Staff used a rainbow grading system to assess each patient's level of risk. All new patients were placed on the red level until staff could assess their level of risk. Physical assessments included a physical examination and checks of the patient's blood pressure, heart rate, respiratory rate and oxygen saturation.

Across the services, care plans were personalised, holistic and recovery orientated. In addition to reflecting patients' mental health, compliance with medicines, regular contact with nursing and multidisciplinary staff, they included information on the mother's needs about parenting a young baby. Care plans contained patients' wishes and goals.

Best practice in treatment and care

Staff in the MBU's multidisciplinary team had completed training in dialectical behavioural therapy (DBT) and were in the process of developing a weekly 8-12 week long DBT programme including emotional regulation and mindfulness. They had completed a pilot with staff and planned to deliver it to patients on an individual basis.

Occupational therapists in the MBU provided a range of group activities including cooking, gardening, relaxation, breakfast and recovery. They also worked individually with patients including helping to develop cooking skills and completing cooking assessments. There were also a range of groups all patients could access on the main occupational therapy site once staff referred them, for example pottery, woodwork, art and gardening.

In line with the National Institute for Health and Care Excellence (NICE) guidelines for antenatal and postnatal mental health, the services provided support for patients who experienced difficulties with the mother–baby relationship. This involved staff assessing the nature of this relationship, during postnatal contact, and exploring any concerns on the mother's part, with interventions focused on improving the mother-baby relationship. This included video interactive guidance, where staff could film patients interacting with their baby and replay it back to them. Staff felt it would be helpful for all staff across the teams to be able to access this training. Staff also conducted new-born behavioural observations and taught infant massage (individually and in groups). The service had links with the Parent Infant Psychotherapy service within the trust and could refer parents to this service if they chose. The trust had plans to offer the Circle of Security parenting programme later in the year to families accessing perinatal services.

The teams delivered formal psychological and psychosocial interventions by clinical psychologists, nursery nurses and perinatal nurse specialists with additional training in cognitive behavioural therapy or systemic family therapy. Specialist supervision was provided for these clinicians, and outcome measures used, ensured that patients/family were involved in reviewing the outcome of treatment.

Psychological treatments offered, in accordance with NICE guidance, included cognitive behaviour therapy for depression (including relapse prevention), obsessive compulsive disorder (OCD), body dysmorphic disorder (BDD), health anxiety, and post-traumatic stress disorder (including post birth). Nursing and psychology staff in the community teams provided weekly cognitive behavioural therapy sessions for up to 24 weeks. They could assess and meet with patients in their homes where required. Psychologically informed birth planning was provided. Behavioural couples' therapy was also provided for depression and bipolar depression, and exposure and response prevention for OCD and BDD. Interventions of choice were influenced by a number of factors including the duration of the episode of illness, the trajectory of symptoms, previous response to treatment, likelihood of adherence to treatment, and the patient's treatment preference and priorities.

For patients presenting with an eating disorder within the perinatal period access to co-support from a specialist service could be facilitated in line with NICE guidance. Patients with borderline personality disorder would not routinely be offered brief psychological interventions for that condition but would be referred to a specialist personality disorder service, co-working with that

service. Some staff across the service, were undertaking training in dialectical behavioural therapy to better support patients with personality disorders.

The service was aware of types of therapy that they were not yet able to provide, including family intervention for psychosis (although this could be accessed via another trust service). Two clinicians in the service were in the process of completing training in eye movement desensitisation and reprocessing (EMDR) training, so that this would be available for patients requiring a trauma focused psychological intervention.

Teams sought to provide psychological therapy within NICE recommended timeframes by assessing patients within two weeks and providing treatment within four weeks. However, they were not meeting this target, and waiting times for psychological interventions varied across the community perinatal teams. Croydon reported a waiting time of approximately nine weeks, with 15 people waiting. In Lambeth, waiting times were eight weeks, with six patients waiting. In Southwark waiting times were between 12-16 weeks, with 10 patients waiting. In Lewisham waiting times were 16 weeks, with 10 patients waiting. The trust provided plans to address the waiting times in each team, including recruitment of more psychologists, and assistant psychologists (to support group work).

Staff used a variety of recognised rating scales to assess and record severity and outcomes, including Health of the Nation Outcome Scales (HoNOS), Patient Reported Outcome Measures (PROM) CORE-10, and the Postpartum Bonding Questionnaire.

Staff participated in clinical audits of the MBU, and outcomes of the perinatal community teams. For example, staff completed audits on care plans, risk management plans, infection control, clinic rooms and equipment.

When patients required specific physical health checks, such as blood tests, because of the medicines they were prescribed, psychiatrists liaised with the patient's GP to ensure the appropriate medical monitoring occurred. Staff could view GP records through an electronic portal system.

Skilled staff to deliver care

Staff were appropriately experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Senior staff were experienced within their roles. Staff completed competencies to assess their ability to use medical devices safely and effectively, and for the administration of medicines. However, there were no perinatal specific competencies for the MBU or community teams.

In addition to the trust induction, managers provided new staff with a comprehensive induction orientating them to the MBU or community team, and with opportunities to shadow staff working in other teams, on the maternity wards, or at the MBU. Agency and bank staff had an induction checklist they completed when starting work for the service.

All staff were expected to receive monthly management and clinical supervision. However, as recorded in the table below, there had been occasions within the last six months, when supervision levels had fallen significantly. In the MBU supervision rates had fallen in the last five months, to a low of 67% in March 2019. Southwark perinatal community team had reduced supervision rates in the last two months, with 60% provided in March 2019. Staff told us that this was largely due to shortages in staffing numbers during these months. Staff told us that they felt supported by their managers, who were always available for informal supervision support.

Records showed, and staff confirmed that they received an annual appraisal in line with trust policy.

Perinatal supervision logs

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Croydon Perinatal	50%	100%	100%	100%	100%	100%
Lambeth Perinatal	100%	100%	100%	80%	100%	78%
Lewisham Perinatal	100%	100%	100%	100%	100%	100%
Southwark Perinatal	100%	100%	86%	100%	75%	60%
Mother & Baby Unit Inpatient	88%	81%	73%	73%	74%	67%
Average Percentage	**88%**	**96%**	**92%**	**91%**	**90%**	**81%**

Staff across the core service told us that they had access to reflective practice groups which were facilitated by a psychologist from outside of the team, and they found this useful.

Managers dealt with poor staff performance promptly and effectively. Managers reported that they received appropriate support from their line managers and the trust's human resources department.

Managers encouraged and supported staff to attend external training and with their career progression. On the MBU, staff attended weekly teaching sessions, where they took turns in delivering training to the team. Staff completed specialist training including on the parent-infant interaction observation scale (PIIOS) and neonatal baby observation (NBO). Staff at the MBU had recently received smoking cessation and updated medicines training.

Staff in the community teams attended perinatal training bi-monthly, recent topics included working with loss, improving outcomes, personality disorders and parenting, and supporting inter-racial families. One practitioner advised that they were due to attend a conference on the fear of childbirth. Another staff member said that they were working towards a Masters' advanced nurse practitioner course funded by Health Education England. The Southwark community team provided training for midwives on mental health and how to identify patients who may require a referral.

Southwark, Lambeth and Lewisham community teams received NHS England wave 1 funding in 2016 and the Croydon team received wave 2 funding in 2018. This meant that the teams could

increase their staffing to support more patients, reduce waiting times and provide more psychological therapies.

Multidisciplinary and inter-agency team work

On the MBU staff shared information about patients at effective handover meetings between staff shifts. These involved the multidisciplinary team working together collaboratively to deliver patient care. We attended a shift handover at the MBU and observed that each patient was discussed in detail using a holistic approach. For example, staff considered whether steps had been taken to register a baby's birth, staff clarified the maximum dose of medicines a patient could have in 24 hours and discussed physical health needs of a patient.

Each staff team had their own weekly schedule of multidisciplinary team meetings throughout the week. These different meetings had a specific function and agenda such as ensuring there was prompt discussion and planning in relation to screening and allocating new referrals and the management of high-risk cases. All teams used multidisciplinary meetings effectively to manage duty work and safeguarding issues and to discuss complex cases. The ward manager on the MBU was planning an away day for staff, to mark the unit's 40th birthday. Each community team had an away day each year, used to facilitate team development.

Teams had monthly business meetings and any outstanding issues were discussed at the perinatal pathway meeting. Some staff were working with NHS England and Health Education England to develop a career pathway and specialist roles within perinatal services. The trust held monthly senior management transformation meetings across all four boroughs to discuss their operational policies, key performance indicators and outcome measures.

In the MBU, the multidisciplinary team included psychiatrists, registered nurses, nursery nurses, unregistered nurses, occupational therapists, two social workers, a clinical psychologist, and developmental psychologist, and an administrator. The team had regular links with a health visitor and midwife team. Staff told us that it was very beneficial having both an adult and a child social worker in the team, to ensure that they maintained focus on the babies in the unit.

The community teams included psychiatrists, registered nurses, nursery nurses, occupational therapists, and clinical psychologists and administrators. There had been a social worker providing support across the four teams, but this post was vacant, and staff were not clear if it would be filled. To increase the level of occupational therapy support, teams had started to receive trainee occupational therapists on rotation, to provide support with group work. Two midwives had been working across the three teams, however at the time of the inspection, their posts were under consultation. The NHSE staffing specification for Perinatal CMHT removed the midwifery post in 2018. Staff told us that this decision had had a negative impact on staff morale. They noted that the midwives had provided much needed education to colleagues on the maternity wards regarding support of patients with mental health issues, and support in formulating pre-birth plans.

Nurses told us that they had no equipment to use for measuring patients' physical health. Whilst this was usually carried out by their GPs, they noted that there were times when this was needed for patients unable to access their GP.

The community teams worked closely with the midwife, health visitor, psychiatric liaison, home treatment, community mental health and safeguarding teams as well as children centres, GPs, schools and the mother and baby unit. For example, the Lambeth perinatal community team liaised with and shared care plans with the midwife team based onsite at the hospital.

Staff from the Croydon community team attended the vulnerable women's group at Croydon University Hospital to identify patients known to the team and work with agencies to support the patients.

The nursery nurse on the Southwark community team delivered baby massage classes for patients and was supporting a baby massage class starting in Lewisham.

Adherence to the Mental Health Act (MHA) and the Mental Health Act Code of Practice

Training in the Mental Health Act (MHA) was mandatory for all inpatient and community staff and renewed every three years. Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice.

The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local MHA policies and procedures and to the Code of Practice through the trust intranet.

Patients had access to information about independent mental health advocacy (IMHA) on the MBU. Staff explained to patients their rights under the MHA, in a way that they could understand, repeated it as required and recorded that they had done so.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave the hospital) when this had been granted. Patients' section 17 leave was discussed at regular multidisciplinary meetings.

On the MBU there was a part time adult social worker who provided in-house training sessions for staff regarding the Mental Health Act. During the handover meeting we attended, we observed staff checking if patients had had their rights under the MHA repeated to them as appropriate.

Good practice in applying the MCA

Mental Capacity Act (MCA) training was mandatory for all inpatient and community staff and renewed every three years. Staff had a good understanding of the MCA, including the five statutory principles, and told us that they discussed capacity to consent in regular multidisciplinary meetings.

Staff knew where to get advice from within the provider organisation regarding the MCA, including deprivation of liberty safeguards (DoLS). Staff at the MBU could seek advice from social workers within the team.

Inspection of patient records indicated that staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make a decision. Staff carried out best interest meetings when patients did not have the capacity to make a specific decision.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately on a decision-specific basis. Doctors and nurses completed assessments of capacity to consent to admission and treatment for all patients and recorded this on the electronic patient record.

Staff gave examples of when they had completed mental capacity assessments on patients, such as when a patient was creating a birth plan. They described cases in which a court of protection order might be required to make decisions about a caesarean section or instrumental delivery, for a patient in their (and the baby's) best interests.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

We spoke with 17 patients, including three from the MBU, and 14 from the community perinatal teams as part of the inspection. Patient feedback was very positive about the quality of care they received across all services.

Patients on the MBU told us they felt safe on the ward, that staff treated them with dignity and respect, and helped them with their recovery. There was a mural of a 'tree of recovery' in one of the communal areas, which was used to share messages of hope from patients who had made positive progress whilst on the unit.

We observed staff and patient/carer interactions during our inspection of the MBU. Staff demonstrated a good understanding of patients', babies', and carers' needs and interacted with them in a respectful and responsive way.

Staff supported patients to understand and manage their care, treatment or condition and develop parenting skills. Staff met with patients on an individual basis each day, and through multidisciplinary ward rounds to discuss their care and treatment with them. All patients we spoke with said they felt involved in their care and treatment.

Staff directed patients to other services when appropriate and, if required, supported them to access services. For example, they encouraged patients at the MBU to go to a baby massage group in the local community.

In addition to general admissions to the MBU, patients were also admitted for parenting assessments. Staff were aware that this could be very stressful for patients and made an effort to make them aware of likely recommendations throughout the process, rather than waiting until the end of the assessment. Staff spoke sensitively about how they supported patients as far as possible, when difficult decisions were reached, and their need for support in turn from the care team which was provided through reflective practice sessions.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. There was a room that could be used for multi-faith worship in the MBU, and staff told us that they had provided support to patients wishing to observe Ramadan. In the community perinatal teams, a patient told us that initially appointments were in the mornings which they found particularly difficult. This was rectified quite quickly with appointments being scheduled in the afternoon with text messages before staff arrived.

Staff maintained the confidentiality of information about patients. Staff were clear that they would raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and did not have a fear of negative consequences to doing so.

The 2018 Patient-Led Assessments of the Care Environment (PLACE) score for privacy, dignity and wellbeing score for the Bethlem Hospital in which the MBU was based, was 92% compared to an overall average score of 89% for the trust and 99% for mental health services in England.

Patients told us that staff in the community perinatal teams were welcoming, helpful and caring including reception staff, and that they could generally see staff as often as needed. Only one community perinatal team patient indicated that one community perinatal professional had been insensitive and not offered personalised care.

Patients told us that staff took time to get to know them and build up a relationship with them and relevant family members. However, they did note that it could be difficult when staff in the teams

changed, meaning that they had to get used to other staff in the teams. They did say that this was handled as seamlessly as possible, with a proper handover to the new staff member.

Patients were overwhelmingly positive about the perinatal services, telling us that they could not have managed without this support, and speaking of support being tailored to them, and increased when needed. Patients talked of nurses always being there for them and showing genuine concern and love. They told us that they were given clear information, and advice as to what to do in the event of a crisis. Two patients said that they would have liked more home visits, and one patient said that they had a long wait when referred to the service, without any information given about the timescales to expect. One patient commented on the setting of the Lewisham perinatal team within an acute mental health hospital, not being particularly suitable for mothers with young babies.

Involvement in care

Involvement of patients

On the MBU, staff used the admission process to inform and orient patients to the ward. Patients told us that they were made to feel welcome on the ward and had received a welcome pack, with relevant information about the unit.

Staff involved patients in care planning and risk assessment. This was demonstrated through inspection of patient care records and patients' feedback when we spoke with them. Patients confirmed that they were offered a copy of the care plan.

We observed that staff communicated with patients so that they understood their care and treatment. Staff spoke to patients clearly using language that was easy to understand.

Staff involved patients when appropriate in decisions about the service. The trust had an involvement register and patients were involved in the recruitment of staff and consultations about service developments.

Staff enabled patients to give feedback on the service they received. For example, the MBU held weekly community meetings. During these meetings patients were encouraged to speak and be involved in the meeting and raise any issues of concern. Staff kept written minutes of these meetings, and they were displayed on a notice board for patients to read. Senior management spoke of plans to introduce 'you said, we did' boards for the services to demonstrate that they responded to patient feedback. We noted that issues raised in community meetings at the MBU were taken forward, including maintenance issues, suggestions for activities, and consultation about food provided. At the most recent meeting, patients had requested a dimmer light switch for the nursery, and more activities to undertake with their babies.

The trust collected regular feedback from patients about their experiences of care and treatment. Patients were asked to complete a brief survey stating whether they would recommend the service to a friend of a family member. We looked at the result of seven recent patients' surveys from the MBU, and 29 from the community teams. The results of these surveys indicated high rates of satisfaction.

Staff ensured that patients could access advocacy. Staff displayed information on how patients could contact an advocate on the MBU. Patients could access pharmacy staff, or a medicines help-line regarding any queries they had about their prescribed medicines.

Patients were given information and encouraged to use local community services such as baby rhyme time, and baby bounce groups, children's and carer's centres. Nursery nurses told us that

when it was thought to be helpful, they would accompany patients to introduce them to their local children centres and other groups, including during pregnancy if a patient was particularly anxious about the support available to them. One nursery nurse advised that they had received training in 'Mellow Parenting,' an emotional parenting programme, and were looking to create a group for mothers in their local community perinatal team.

Community teams had recently set up a service user forum across all four boroughs that met every six to eight weeks. Patients provided feedback and input on services, training and policies and helped with recruitment.

A project was underway to coproduce a service user and carer's leaflet, to be used across the community teams, with input from a psychologist, and coproduction lead.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff supported carers to access a carer's assessment and gave information on local support groups for carers.

On the MBU staff took account of the views of all parties with parental responsibility for the babies on the wards. Staff asked patients who was important to them and how the patient would like the team to communicate with their family and others.

Care and treatment records showed that, when appropriate, staff worked closely with the family and carers, involving them in meetings to discuss the patient's care and treatment. At the time of the inspection, there was no fathers/partners group in place at the MBU. Staff had undertaken a recent survey of the views of fathers/partners of patients on the unit, to find out their preferences for support. This indicated that rather than a fathers/partners group, more individual outreach work might be their preferred means of support.

Staff in the community teams described how they worked with their patients' families and partners and involved them in patients' care, and parenting support. The community teams had plans to set up a group for fathers/partners and signposted partners to where they could get support in the community. Teams provided family and couple therapy with patients.

Staff enabled families and carers to feedback on the service they received. For example, via surveys saying whether they would recommend the service to people they know.

Is the service responsive?

Access, discharge, and waiting times

The MBU was a national service with clear criteria for admission, including taking patients at risk of serious mental illness, from 32 weeks of pregnancy or earlier if there was a clinical need. Referrals were received electronically through a bed management programme run by NHS England. They came from a range of services, including through GPs, accident and emergency, community mental health teams, and maternity services. Referrals were screened, and patients assessed for admission by senior clinical staff, within 24 hours of acceptance. Priority was given to women at home, without support networks in place.

The average length of stay for patients on the MBU was 53 days at the time of the inspection. However, some patients stayed for significantly longer. At the time of the inspection, there was one delayed discharge from the service, due to the patient's local community mental health team not having the resources to be able to take on responsibility for this person for the next three

months. Staff spoke of a need for a day hospital service, and more assertive outreach provision for patients in this position.

Referrals to the community perinatal teams, were only accepted for patients living in, or being treated/giving birth in a hospital in the four local boroughs. Referrals went to a dedicated email address, which administrative staff processed for each team on a rotational basis. Staff in community teams held approximately 25 patients on their caseload. Staff could see patients on site, do home visits or meet them in the community. Staff supported patients with moderate to severe mental health needs including anxiety, depression, obsessive compulsive disorder and personality disorder. The teams worked with women from pre-conception until their child's first birthday.

Staff on community perinatal teams were on a duty rota to do assessments and answer phone calls, for example from doctors about medicines or whether a patient met the threshold for referral.

The Lambeth team supported patients who came from around the country as the acute hospital supported patients with difficult births. Staff liaised with patients' local teams to transfer their care after discharge.

Each community perinatal team held a referral meeting daily. We attended two of these meetings, and found that where needed, staff would contact the referrer for more information, such as whether the patient has been consulted about the referral. Staff had duty systems which ensured that staff were always available to respond to urgent referrals. Staff checked that risks had not increased when there were waiting lists for non-urgent assessments. Patients told us that the teams were responsive when they telephoned for advice and support. Waiting times after referral to be seen by a nurse or doctor differed between teams and depended on urgency. Most patients were seen by a nurse within two weeks, and a doctor within four weeks. However, in Lewisham waiting times to see a doctor were six weeks. Teams were meeting the target of seven day follow up for patients discharged from inpatient wards, with support from the home treatment teams.

Staff in the Lewisham team reported the highest number of patients under 18, and a high level of complexity due to changes in the local population, with high rates of teenage pregnancy. They supported young people to use the service, working jointly with child and adolescent mental health teams. At the time of the inspection, the Lewisham team had the highest caseload with 206 patients, compared to 181 in Southwark, and 141 in Lambeth. Numbers were significantly lower in Croydon, as they were a much smaller team that had not yet achieved the full impact of the wave 2 funding. The occupational therapist in the group had introduced a discharge group to work with patients ready preparing for discharge from the team over a six-week programme.

The Southwark team noted that they had superseded NHS England expectations for the rate of growth in the number of patients they were able to see. In Southwark there was a parental mental health team that patients could be referred to after the child's first birthday, but this was not available in the other boroughs. The Lambeth team had one patient whose discharge from the team was delayed by three months due to a waiting list for the home treatment team.

Staff made repeated attempts to make contact and engage with patients. Staff used text messages, phone calls, letters and unannounced visits. Staff used multidisciplinary team meetings to discuss risks and plan alternative interventions when patients did not wish to engage with the service. Staff told us that if patients did not attend appointments, staff used the time of the appointment to try to contact them.

Patients told us that staff were reliable and kept appointments. Teams were flexible about the timing and location of appointments and offered evening appointments when necessary.

Staff supported patients during referrals and transfers between services. For example, staff kept in touch with patients who were admitted to general or mental health hospital wards.

Facilities that promote comfort, dignity and privacy

In the MBU patients were provided with single bedrooms, with space for a cot, with shared toilet, bathroom and shower facilities. Their privacy and dignity were supported by having a vision panel on their bedroom door, which could be controlled by both the patient and staff. Patients could personalise their bedrooms, for example by bringing in family photographs and babies' toys. Patients could make a phone call in private. Patients kept their mobile phones with them to contact friends and families. If patients did not have a mobile phone, they could use the ward's cordless mobile phone. They also had access to two tablets and Wifi on the unit.

Patients had a safe in their bedrooms in which to store valuables. Staff and patients had access to the range of rooms and equipment to support treatment and care. The ward had an occupational therapy kitchen, conference room for groups and visitors, clinic room and visitor and resource room. There was also a nursery area for babies that was always supervised by two staff, a laundry room, sensory room, baby sleep room and milk room, and high chairs and other equipment to support care of their babies.

The ward had an outside courtyard. Due to a recent ligature audit, the courtyard was locked and only accessible with staff supervision. There were numerous cigarette butts in the courtyard from patients in the above ward. The ward was in the process of getting a new garden area, however there was no timeline for completion. There were quiet areas on the ward and a room where patients could meet visitors, although these were limited in size.

Overall staff told us that the MBU had outgrown its environment. Its lack of ensuite facilities, an insufficiently large nursery, a lack of safe garden space, and not enough space for patients to meet with visitors, all impacted on patients' and babies' comfort. Consideration was being given to moving the parenting assessment part of the service to another location.

During the week of our inspection, new furniture was being delivered including more cots for the nursery sleep room, new nursery furniture, and dining room tables and chairs. The unit was due to be repainted, and there were plans to renovate the baby change area and milk kitchen.

Most patients said they were happy with the quality and selection of food, although options could be somewhat limited during weekends. The ward provided breakfast clubs for patients to prepare their own breakfast twice a week and the occupational therapists also supported patients with cooking. Patients could make hot drinks and snacks at any time of day or night.

The ward had a "you said, we did" board, which showed how staff had responded to patients' feedback. This included changing the lighting in bedrooms to have a softer lighting option that didn't disturb babies. Patients also asked staff to simplify the observation levels as they found them confusing, so staff introduced the rainbow system that was colour coded and patients found easier to understand.

Staff spoke highly of the environment in which the Croydon perinatal team was based. The Southwark perinatal community team base's environment at King's College Hospital, was poor. The team sat within the psychological medicine department. There were not enough rooms to meet with patients. The décor of the rooms was not welcoming – one room had large pieces of paint flaking off the walls and a chair with a ripped seat. The rooms did not provide adequate privacy to meet with patients or for those who needed to breastfeed their baby. Staff said that they

would be able to offer more to patients, for example deliver groups and see more patients on site if they had more available space.

The Lambeth perinatal community team base at St Thomas's Hospital was also problematic. There were insufficient rooms to meet with patients, and computer terminals to update records. There had also been an infestation of fruit flies, and ongoing problems with mice due to the hospital's proximity to the river. The accommodation for the Southwark and Lambeth teams were on the trust risk register, and we were told that senior staff were trying to locate new, more suitable premises, however no plans were confirmed.

The Lewisham perinatal community team base at the Ladywell Unit, also had insufficient rooms available for seeing patients. Staff told us that they had come close to cancelling patient appointments when they had been unable to find a free room. They also noted that the location of the team within an acute mental health unit was not ideal for mothers with young babies.

Patients' engagement with the wider community

Staff on the MBU supported patients to maintain contact with their families and carers. With the consent of patients, staff invited families and carers to multidisciplinary meetings and encouraged patients to utilise leave with their loved ones.

Staff on the MBU and in the community teams signposted patients to appropriate local community groups and facilities and supported them to attend. Staff escorted patients on leave in the community to build up their confidence with activities in the community.

Staff were familiar with the available resources in their local area and made sure that patients were introduced to them. These resources included children's centres, community groups in libraries, and other community centres. Patients were positive about the way staff had helped them to access community support.

Meeting the needs of all people who use the service

The MBU was on one floor, with non-step access for physically disabled patients and mothers with babies in prams. The locations of the community teams also had step free access, with lifts available between floors. There was one larger bedroom in the unit, that would be made available to patients who used a wheelchair, this room could also be used for mothers of twins, or parenting assessments.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, local cultural groups, and how to complain. This information was displayed on notice boards on the MBU and at each of the community team locations.

Staff said if there was an identified need they could access leaflets and documents in different languages via the trust intranet. Managers confirmed that staff and patients had easy access to interpreters and/or signers. Staff told us of a case in which they were able to facilitate a patient's request by locating a clinician who spoke their language, instead of using an interpreter.

Staff supported individuals who identified as lesbian, gay, bisexual or transgender (LGBT+). For example, some staff wore the trust's rainbow coloured lanyard attached to their staff ID to indicate that they were supportive of LGBT+ patients.

Patients on the MBU had a choice of food to meet their religious or ethnic dietary requirements, or beliefs. This included halal and vegan options, with the options of ordering other requirement such as gluten free meals. Staff on the MBU ensured that patients had access to appropriate spiritual support, with information displayed about the chaplaincy service that patients could access. Staff

told us that they were able to provide patients with a room to use for multifaith worship and could support patients to observe religious festivals such as Ramadan.

In the community teams we saw that reception areas had a wide range of relevant leaflets and posters on display for patients, including information on advocacy.

Listening to and learning from complaints

Most patients knew how to complain or raise concerns. On the MBU and at each community team location staff displayed information on how patients could make a complaint.

Team managers followed trust procedures to log and respond to formal complaints. Additionally, they ensured that patients and carers could raise any concerns with them at the earliest possible stage. Managers told us how they met with patients and staff to clarify issues and to ensure a positive outcome.

Staff received feedback on the outcomes of investigations of complaints and acted on the findings. Staff included discussion about the outcomes of investigations into complaints as a standing item on the agenda for team meetings. The table below shows the MBU complaints, compliments and comments (CCC) received between 1 April 2018 and 31 March 2019.

Summary re Type of CCC

Team/Ward	COMP - Formal Complaint - Service Level	PALS - Information	Thank You	Total
Mother & Baby Unit (Inpatient), BRH	2	1	5	8
Total	**2**	**1**	**5**	**8**

Summary re Subject and source of CCC

	Source of CCC				
Subject of CCC	Family/Friend/Relative	Service User	SLAM Staff	(blank)	Total
Behaviour		1			1
Co-ordination of treatment	1				1
Detention Circumstances	1				1
Other	1	1	1		3
Other (not listed)		1			1
(blank)				1	
Total	**3**	**3**	**1**	**1**	**7**

For the same period, two complaints were received by the Lambeth community perinatal team, two by Croydon, and nine by Lewisham and Southwark (combined). Staff were able to tell us

about changes that had been made as a result of complaints. These included review of the MBU search policy, and search training provided to staff, and improved communication between teams.

Is the service well-led?

Leadership

We spoke with senior staff from the Psychological Medicine and Older Adult directorate, which covered specialist services including the perinatal services. They demonstrated a good understanding of the perinatal inpatient and community services they managed and could explain how the teams were working to provide high quality care.

Leaders had the skills, knowledge and experience to perform their roles. Senior staff in the directorate did not necessarily have perinatal mental health experience. However, all the team managers were registered health professionals with experience of working in perinatal mental health services.

Most staff confirmed that leaders were visible in the service and approachable for patients and staff and knew their senior managers within the directorate. Some staff spoke of a lack of clear communication from senior management about changes in the service. The loss of the two midwife posts in the community teams, had a significant impact on staff morale in the teams. The recent advertising and then withdrawal of a registered nurse post in the Lewisham perinatal team after staff had applied for this due to a system upload error, also led to confusion and frustration. The trust told us after the inspection that the vacancy had since been appointed to.

Managers were well-informed about the operational performance of their teams and any areas for improvement. In the community teams, band 7 nurses managed other band 7 nurses in the team, with a reduced caseload (except in the case of Lewisham due to staff shortages). Staff indicated that this had not led to any problems but was not common practice in other neighbouring trusts.

Staff said that team managers consistently demonstrated their leadership and commitment and made themselves available to staff for advice and support. All managers were based within the services they managed and worked directly with their teams. Staff said managers were hands-on and when necessary would undertake direct work with patients.

Leadership training and development opportunities were available, including opportunities for staff below team manager level.

The MBU team was managed by a band 8a clinical services lead in keeping with other specialist units, although staff said they were not consulted on this change. The clinical services lead advised that they were looking at the possibility of having a practice development nurse instead. The MBU shared a modern matron with two other services.

Some staff said that when the community teams went through the most recent transformation after receiving funding from NHS England, the trust did not manage the change well. Staff said they did not have clear communication about the changes, were not consulted on the changes and there was a lack of direction and clarity. Staff said that when the service changed directorates, they found the new senior managers more visible and approachable.

Vision and strategy

Staff knew and understood the provider’s vision and values and how they were applied in the work of their teams. The visions and values were displayed on the MBU and in the community teams and staff were committed to them.

Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

Staff we spoke with said they felt respected, supported and valued by their colleagues and line managers. Staff said that their current managers promoted a positive and open culture.

Staff felt positive and proud about working for the provider and their team. Several staff we spoke with said how they get job satisfaction by seeing mothers recover on the MBU learn to bond and return home with their baby within a relatively short amount of time.

Some staff, particularly in the community perinatal teams felt stressed and under pressure due to shortages of permanent nurses, and psychiatrists in some teams. However, they noted that they were supported by cohesive teams, with regular supervision and reflective practice. Staff also attended annual away days to aid team development.

Staff we spoke with said they felt about to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian.

Staff appraisals included conversations about career development and how it could be supported. Several staff had worked at the trust for many years and had been promoted within the service and across the teams.

Managers and staff told us that any issues of poor staff performance or other staff difficulties were dealt with. Managers could access support from senior managers and trust specialists if there were concerns about performance.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The trust held an annual staff awards event. Staff could nominate teams or individuals for awards such as kindness and caring, transforming lives and the team of the year.

Governance

The perinatal services were managed through the Psychological Medicine and Older Adult directorate. There were current protocols in place in the form of operational policy documents for the running of the MBU and perinatal community teams.

There was a clear framework of what must be discussed at team and senior management level. For example, monthly staff performance and quality (business) meetings followed a clinical governance structure where pertinent issues such as working environment, incidents, complaints, best practice and performance data were discussed. These meetings then fed into pathway and transformation meetings with senior managers in the directorate.

The trust was aware of the need to continue with its recruitment and retention drive to address vacancies amongst the teams and reduce reliance on bank and agency staff. Rather than be part of general recruitment drives, senior managers had agreed that perinatal staff could advertise specifically for staff interested in working in perinatal services.

Senior managers completed regular Quality, Effectiveness and Safety Trigger Tool (QuESTT) assessments of each ward to identify if they needed extra support. The assessment looked at vacancy rates, bank usage, sickness rate and supervision rate. Senior managers arranged for mock CQC inspections for each team, so that they would be aware of what was involved during an inspection and identify improvements to be made in patient care.

Staff implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level. Staff undertook clinical audits and used these to gain assurance about the services provided including the environment, care records, and medicines management.

Teams had a good understanding of their role in the care pathway and had positive working relationships with GPs, other community teams and inpatient services. The service published an annual report for community perinatal mental health services covering Lambeth, Southwark and Lewisham (NHS England Wave 1) in January 2019. This included case studies, details of service activity, analysis of outcome data, and patient and family feedback.

Management of risk, issues and performance

Staff could escalate concerns to the trust risk register when required from a team level. Senior managers were well-informed about risks. The MBU used QuESTT which identified key areas of risk within the service and actions to mitigate the risks identified. This ensured that the local and trust wide leadership teams were able to identify any issues rapidly and address them to maintain good quality of care. The key risks from the QuESTT were identified on the risk register so that priorities for actions could be taken.

Senior managers were aware of problems with the environments in the MBU and community teams, including poor temperature control, and lack of sufficient space to meet with patients. They were also aware of staffing recruitment and retention issues, and some issues of poor morale within the community teams. They had plans in place to address these issues, as far as possible, when they were within the trust's control.

The service had plans for emergencies such as adverse weather or outbreak of an infectious disease.

Information management

The service used systems to collect data from the MBU and community teams that were not over-burdensome for frontline staff. None of the staff we spoke with raised concerns about data collection.

Staff generally had access to equipment and information technology needed to do their work. The MBU had computers for staff to access electronic records. However, some bank staff described long waits for IT equipment including laptops and phones.

Team managers had access to information which helped them to do their jobs, including staffing information like vacancy rates, appraisal rates and mandatory training records. Team managers noted that due to staff recording care plans and risk assessments in different formats, the dashboard showed much lower compliance in these areas than was the case. A project to produce bespoke perinatal electronic care records, was underway to address this issue.

Staff made notification to external bodies as needed. For example, the service reported serious incidents to the Strategic Information Executive Service at NHS Improvement.

Engagement

Staff, patients and carers had access to up-to-date information about the work of the trust and the services they used. Staff had opportunities for engagement through information which was provided on the trust intranet including regular newsletters and email bulletins when there was specific information of direct relevance. Patients and carers had access to a variety of leaflets at

the services and could apply to join the trust's involvement register if they wished to take part in relevant projects and be involved in recruitment interviews.

Patients had opportunities to feedback about the service through MBU community meetings, multi-disciplinary meetings and surveys.

Patients and carers were encouraged to complete family and friends' tests to provide the trust with feedback. Feedback was gathered through paper forms as well as online forms. Patients and carer feedback were discussed in local team meetings and directorate-wide clinical governance meetings.

Directorate leaders engaged with external stakeholders, such as commissioners, GPs and voluntary organisations at consultation events. Within the last year the MBU had received a royal visit, and had facilitated filming of consenting patients for a documentary about perinatal mental health, to improve public awareness about the issues involved.

Learning, continuous improvement and innovation

Staff said there were opportunities for them to be involved in quality improvement (QI) initiatives.

One QI project at the MBU improved the nursing handover to make it more focused on what actions needed to be completed in the following shift for each patient. Another project improved the ward round so fewer staff attended the meeting, but feedback from all staff was collected prior to the meeting. Staff said this helped to make the ward rounds less intimidating for patients and more patient centred. Staff at the MBU were also implementing 'Four steps to safety,' a QI initiative to reduce the likelihood of violence and aggression.

In the Lambeth community perinatal team, staff spoke of plans to start a QI project around time management, about the number of meetings they were attending with the host trust. In Lewisham community perinatal team staff were planning QI projects on the substance misuse pathway, and making the team meeting as effective as possible, in addition to reducing patient waiting times. All the community teams had plans to provide more group sessions for patients and to further develop their work with the local children's centres.

Staff attended various local and national networks including the perinatal social work national group and London group. Some staff on the teams completed peer reviews of other services for the perinatal quality network and brought learning back to their services. Similarly, staff from the MBU visited a new MBU service within the London area to learn about the challenges and possibilities of a bespoke environment.

The team leader of the Croydon community perinatal team founded and chaired the pan-London perinatal nurse's network where staff across all community perinatal services in London met four times a year to share learning and best practice.

The MBU ward was accredited with the Royal College of Psychiatrists College Centre for Quality Improvement in 2017. Psychiatrists from the service had cowritten a paper with other psychiatric colleagues titled 'Mother and Baby Units matter: improved outcomes for both.' This paper was published in the British Journal of Psychiatry.